ALABAMA MEDICAID AGENCY MATERNITY CARE PROGRAM OPERATIONAL MANUAL

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OPERATIONAL MANUAL

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I. OVERVIEW

The Maternity Care Program Operational Manual is provided as a resource tool. For questions or clarification of program policy or requirements, you may contact the Maternity Care Program Associate Director.

A. Maternity Care Program Authority

The program is also governed by the existing State Plan, 1915(b) Waiver, Alabama Medicaid Agency Administrative Code, Alabama Medicaid Provider Billing Manual, Request for Proposal (RFP) Number **2015-MCMS-01** and the Code of Federal Regulations (CFR). It is the responsibility of the Primary Contractor to be aware of and maintain copies of all governing materials.

B. Districts

Primary Contractors for all districts are required to provide maternity care services to all women eligible for the program. The districts and counties are outlined in **Figure 1**.

Figure 1. Districts and Counties

Districts	Counties
1	Colbert, Franklin, Lauderdale, Marion
2	Jackson, Lawrence, Limestone, Madison, Marshall, Morgan
3	Calhoun, Cherokee, Cleburne, DeKalb, Etowah
4	Bibb, Fayette, Lamar, Pickens, Tuscaloosa
5	Blount, Chilton, Cullman, Jefferson, Shelby, St. Clair, Walker, Winston
6	Clay, Coosa, Randolph, Talladega, Tallapoosa
7	Greene & Hale
8	Choctaw, Marengo, Sumter
9	Dallas, Wilcox, Perry
10	Autauga, Bullock, Butler, Crenshaw, Elmore, Lowndes, Montgomery, Pike
11	Barbour, Chambers, Lee, Macon, Russell
12	Baldwin, Clarke, Conecuh, Covington, Escambia, Monroe, Washington
13	Coffee, Dale, Geneva, Henry, Houston
14	Mobile

C. Recipients to be Served

1. The following recipients who are pregnant are required to participate and must be enrolled by the district where the recipient resides:

    a. Those certified under the Affordable Care Act using the Modified Adjusted Gross Income (MAGI) rules for pregnant women with the exception of the Department of Youth Services recipients identified with County Code 69

    b. Those certified through the Parent Other Caretaker Relative (POCR)

    c. Refugees

    d. Supplemental Security Income (SSI) eligible women

2. The following recipients are not required to participate in the Maternity Care Program:

    a. Dual eligible recipients (Medicare/Medicaid)

    b. Individuals granted emergency Medicaid due to their non-citizen status

3. Primary Contractors must follow non-discriminatory standards of care for all recipients regardless of eligibility category.

    a. Ensuring that no person shall, on the grounds of race, color, creed, national origin, age, health status or handicap, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program of services provided by Medicaid.

    b. Compliance with Federal Civil Rights and Rehabilitation Acts is required of providers participating in the Alabama Medicaid Agency.

II. DEFINITIONS

Actuarially Sound Rates

CMS defines actuarially sound rates as rates that have been developed in accordance with generally accepted actuarial principles and practices appropriate for the populations to be covered and the services to be furnished under the contract and certified by an actuary who meets the qualification standards established by the American Academy of Actuaries and follows practice standards established by the Actuarial Standards Board.

Anesthesia

Any sensory and/or motor paralysis for the relief of pain including but not limited to epidural, saddle-block, pudendal block, inhalation central anesthesia, endotracheal anesthesia, or other, which is not medically contraindicated.

Antenatal Care

All usual prenatal services including, but not limited to, the initial visit at the time pregnancy is diagnosed, initial and subsequent histories, Care Coordination, risk assessments, physical exams, recordings of weight and blood pressure, fetal heart tones and rates, lab work appropriate to the level of care including hematocrit and chemical urinalysis, and any additional services required for high-risk women.

Application Assisters

Individuals trained by the Medicaid Agency to assist recipients in completing Medicaid applications.

Benchmark

A benchmark is a standard by which requirements can be measured or judged.

Recipients

Pregnant women who reside in Alabama, are certified for Medicaid and receive pregnancy related services under the Maternity Care Program.

Care Coordination

Management of obstetrical care including recruitment, outreach,

psychosocial assessment, service planning, assisting the recipient in arranging for appropriate services including, but not limited to, applying for Medicaid resolving transportation issues, education, counseling, and follow-up and monitoring to ensure services are delivered and continuity of care is maintained.

Clean Claim

A clean claim is one that can be processed without Medicaid obtaining additional information from the provider of service or a third party insurance carrier.

CMS

Centers for Medicare and Medicaid Services, a division of the U.S. Department of Health and Human Services.

Continuity of Care

Uninterrupted continual care of the Medicaid recipient that is coordinated to address the health care needs among practitioners and across organizations and time.

Contract Services

See "covered services".

Convicted

A judgment of conviction that has been entered by a Federal, State, or local court, regardless of whether an appeal from that judgment is pending.

Covered Services

Health care services, as designated in Section 5, to be delivered by a Primary Contractor or through subcontracts.

Days

Calendar days unless otherwise specified.

Debarment

Debarment is exclusion from participation as a Medicare/Medicaid provider.

Delivery

Delivery is the birth of an infant via vaginal birth canal (with or without episiotomy and with or without forceps), or cesarean

section delivery.

Delivering Healthcare Professional (DHCP)

A licensed physician or nurse midwife who is qualified to perform deliveries, prenatal and postpartum care.

Disclosing Entity

The entity is a Medicaid provider or a fiscal agent.

Districts

Districts are geographic divisions of the State of Alabama as defined by the Alabama Medicaid Agency which comprise the entire state divided into fourteen districts.

Dropouts

A recipient who begins care in the district of her residence but does not deliver her infant within that district's network is considered a dropout. An example of dropout may include someone who moves to another district prior to delivery or one who miscarries prior to 21 weeks.

Eligible

A person certified as eligible to receive Medicaid benefits and who has been issued a Medicaid identification number.

Eligibility

A process of determination of eligibility for medical assistance performed by Medicaid.

Emergency Medical Condition

A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent lay person, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy or serious impairment of bodily functions; or serious dysfunction of any bodily organ or part.

Enrollee

An enrollee is a Medicaid recipient who is currently enrolled in the Maternity Care Program via her district of residence.

Encounter Data

Encounter data are the records of services delivered to Medicaid beneficiaries enrolled in Maternity Care Program for which a capitated payment is made. These records allow the Medicaid agency to track the services received by Maternity recipients enrolled in Maternity Program and set capitation rates. Encounter data typically comes from billed claims that Primary Contractors and providers submit to the Alabama Medicaid Agency for their services.

Fee for Service

A method of Medicaid reimbursement based upon payment to providers for services rendered to Medicaid recipients subsequent to, and specifically for, the rendering of those services. Those services that are payable outside the global fees**.**

Fiscal Agent

The company designated by Medicaid, through contract, to maintain the Medicaid claims processing system.

Fiscal Year

Defined as October 1 through September 30.

Global Fee

The reimbursement fee paid following delivery to the Primary Contractor for recipients who meet the requirements of the Medicaid Maternity Care Program. This fee is a global amount (based on actuarial soundness) paid to the Primary Contractor who, in turn, pays subcontractors who provided services to enrolled recipients. The amount paid to each subcontractor is a negotiated amount between the Primary Contractor and the subcontractor, with Medicaid minimums established for Delivering Healthcare Professionals**.**

Grievance

A grievance is a written expression of dissatisfaction about any matter.

Indicator

An indicator is a measurable dimension of care (e.g., a medical event, diagnosis, or outcome) to reflect aspects of care, the

importance of which is gauged by frequency, severity, or cost.

Material Omission

A fact, data or other information excluded from a report, contract, etc., the absence of which could lead to erroneous conclusions following reasonable review of such report, contract, etc.

Maternity Care Primary Contractor

A person or organization agreeing through a direct contract with the Alabama Medicaid Agency to provide those goods and services specified by contract in conformance with the requirements of the bid and state and federal laws and regulations. **Medicaid**
A Federal/State program authorized by Title XIX of the Social Security Act, as amended, which provides Federal matching funds for a medical assistance program for recipients of federally aided public assistance and SSI benefits and other specified groups. Certain minimal populations and services shall be included.

Medically Necessary

Appropriate and necessary services as determined by health care practitioners according to national or community standards

Medical Record

The document that records all of the medical treatment and services provided to the Medicaid recipient.

Modified Adjusted Gross Income (MAGI)

A Federal mandate, effective January 1, 2014, authorizing States with eligibility coverage groups such as Pregnant Women, Children under age 19, Family Planning, Parents and Other Caretaker Relatives (POCR), and Former Foster Care Children who were affected by the Affordable Care Act of 2010 (aka Patient Protection and Affordable Care Act of 2010) to use Modified Adjusted Gross Income (MAGI) methodology for eligibility determinations for specific groups of Medicaid applicants and beneficiaries such as pregnant women, children under age 19, family planning, and parents and other caretaker relatives.

Party of Interest

A person or organization with an ownership interest with the

Primary Contractor of five percent or more or in which the Primary Contractor has ownership interest of five percent or more.

Performance Measure

A consistent measurement of service, practice, and governance of a health care organization. Measurements shall produce solid, statistically-based measurement of critical processes that, in turn, shall permit the organization to make solid decisions about improvements.

Postpartum Care

Postpartum care includes inpatient hospital visits, office visits and/or home visits by a physician, midwife or registered nurse following delivery for routine care through the end of the month of the 60-day postpartum period (e.g. whether the 60th day is on September 2nd or September 16th, the eligibility continues through the end of the month.)

Potential Enrollee

A Medicaid recipient who is subject to mandatory or voluntary enrollment, but is not yet enrolled.

Pregnant Women

Pregnant Women is an eligibility category for pregnant women within the Medicaid system. Pregnant Women is further defined as maternity services for a woman who is eligible for pregnancy only related care, postpartum and family planning services. These women are maternity eligible until the end of the month in which the 60th postpartum day falls. After Pregnant Women eligibility ends the women are covered by family planning services. These women are also identified as poverty level women.

Pre-Term Delivery

Deliveries occurring prior to 37 weeks gestation.

Program Exemption

A recipient who has an exemption is not required to receive care from the Primary Contractor's network. This is generally as a result of travel hardship or for individuals enrolled in a private Health Maintenance Organization (HMO). The claims for exempted

recipients are paid fee for service if provided by an authorized Alabama Medicaid provider.

Quality Assurance

An objective and systematic process that evaluates the quality and appropriateness of services provided.

Remittance Advice

An explanation of Alabama Medicaid Agency's check writes payment. It lists the paid, denied, adjusted and recouped claims. Remittance Advice was previously called the Explanation of Payment.

Risk Assessment

Medical and psycho-social assessment performed to determine the perinatal risk status of pregnant women. The purpose of the assessment is to determine the presence of any medical and/or social risk factors.

RMEDE

Realtime Medical Electronic Data Exchange, or RMEDE, is the service database for the collection of recipient data so that an accurate reflection of program impact can be obtained.

RMEDE Exemption

A recipient who has an exemption is not required to be entered into the Service database by the Primary Contractor's network. This is generally as a result of deliveries at or less than 21 weeks gestation or other reasons as approved by the Alabama Medicaid Agency.

Risk contract

A contract under which the contractor assumes risk for the cost of the services covered under the contract; and incurs loss if the cost of furnishing the services exceeds the payments under the contract.

Smoker

A person who is actively smoking or using any form of tobacco or who has ceased the use of tobacco products within the last 3 months prior to enrollment in the Maternity Care Program.

Subcontract

A subcontract is any written agreement between the Primary Contractor and another party for any services necessary to fulfill the requirements of the Medicaid Maternity Care Program contract

Third Party Liability (TPL)

Any individual, entity, or program that is or may be liable to pay all or part of the expenditures for covered services furnished to enrollees. The recipient is still restricted to receiving care through the Primary Contractor unless the TPL is a HMO/Managed Care Plan with a restricted provider network, and then a program exemption shall be requested. Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment.

Utilization Review

Prospective, concurrent and retrospective review and analysis of data related to utilization of health care resources in terms of cost effectiveness, efficiency, control, quality, and medical necessity.

III. ADMINISTRATIVE REQUIREMENTS

A. Standards for Primary Contractor

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and shall act in good faith in the performance of the provisions of said contract. The following is a listing of the standards for the Primary Contractor:

1. Demonstrate the capability to serve all of the pregnant Medicaid eligible population in the designated geographical area whether the Medicaid eligible has or has not enrolled in your district.

2. Procure a network of providers within a maximum of 50 miles travel for all areas of their district.

3. Must designate a full time Director for the District(s) who has the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to Federal and State regulations. This full time Director may simultaneously assume the directorship position of more than one district, and must participate in monthly status calls and all called meetings including, but not limited to, the annual face to face meeting.

4. Must establish business hours for the provision of Maternity services. The Director or an appropriately qualified designee must be available and accessible, during business hours for any administrative and/or medical problems which may arise.

5. Must have a system in place to direct after business hours calls for any administrative or any emergency medical problems which may arise. Require subcontractors providing direct medical care to be on call or make provisions for maternity call coverage 24-hours per day, seven days per week.

6. Require that all persons, including employees, agents, and subcontractors acting for or on behalf of the Primary Contractor, be properly licensed under applicable state laws and/or regulations. Any Delivering Healthcare Professional must have hospital privileges at a participating hospital within the Maternity Care program district. Some providers may elect to provide prenatal care only; another provider would provide delivery and postpartum care. In this case there would not be a requirement for the prenatal provider to have hospital privileges.

7. Comply with certification and licensing laws and regulations applicable to the Primary Contractor's practice, profession or business. The Primary Contractor agrees to perform services consistent with the customary standards of practice and ethics in the profession. The Primary Contractor agrees not to knowingly employ or subcontract with any health professional whose participation in the Medicaid or Medicare Program is currently suspended or has been terminated by Medicare or Medicaid.

8. Must require that network providers offer hours of operation that are not less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service.

9. Comply with all state and federal regulations regarding family planning services, including no restriction on utilization of services. The Plan First Program Manager can provide information on available contraception. The sterilization consent form is available on the Medicaid web site.

10. Require all subcontractors providing direct services to meet the requirements of and enroll as Medicaid providers as applicable. This will include any professionals that provide on-call coverage for the network provider.

11. Report suspected fraud and abuse to the Medicaid Agency. The Primary Contractor must have policies, procedures, a mandatory compliance plan, a compliance officer, compliance committee and training education for all of its employees. These policies and procedures must comply with all mandatory state guidelines and federal guidelines as specified in 42 CFR 438.608(b) (1).

12. Prohibit discrimination against recipients based on their health status or need for health services as specified at 42 CFR 438.6 (d) (3).

13. Ensure that medical records and any other health and enrollment information that identifies any individual enrollee must be handled in such a manner as to meet confidentiality requirements as specified in 42 CFR 438.224. Develop and implement procedures consistent with confidentiality requirements as specified in 42 CFR 438.224.

14. The Primary Contractor is not required to reimburse payment, or provide coverage of a counseling or referral service because of an objection on moral or religious grounds in accordance with 42 CFR 438.102 (a)(2). If the Primary Contractor elects not to provide the service, then if must provide the related information to Medicaid so that it can be provided to the recipient.

15. Must comply with State and Federal laws regarding excluded Individuals and Entities. Excluded individuals and Entitles are not allowed to receive reimbursement for providing Medicare and Medicaid services in any capacity, even if they are not on this listing by the Alabama Medicaid Agency.

16. Must comply with State and Federal laws regarding ensuring that contractors and subcontractors are not currently debarred from participation from Medicare/Medicaid programs by checking the System for Award Management, formerly Excluded Party List System (EPLS).

17. Must comply with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) on a monthly basis to determine if any existing employee or contractor has been excluded from participation in the Medicaid program.

18. Must ensure subcontractors are complying with State and Federal laws regarding checking Medicaid's Exclusion List and the List of Excluded Individuals and Entities (LEIE) on a monthly basis to determine if any existing employee or affiliated entities have not been excluded from participation in the Medicaid program.

B. Functions/Responsibilities

The Primary Contractor must comply with all the provisions of the executed contract, its amendments and referenced materials and must act in good faith in the performance of the provisions of said contract. The following is a listing of the functions and/or responsibilities of the Primary Contractor:

1. Provide the pregnant Medicaid eligible population obstetrical care through a comprehensive system of quality prenatal care, physician or midwife delivery care, and postpartum care. The care can be provided directly or through subcontracts. The successful bidder's delivery system will not include the hospital component.

2. Implement and maintain the Medicaid approved quality assurance system by which access, process and outcomes are measured.

3. Provide Application Assister services to Medicaid recipients. (Refer to the information in Attachment Six for details on Application Assisters.)

4. Utilize proper tools and service planning for women assessed to be at risk medically or psychosocially.

5. Provide recipient choice among Delivery Healthcare Professionals in its network.

6. Meet all requirements of the provider network including maintaining written subcontracts with providers to be used on a routine basis, including, but not limited to, obstetricians and general practitioners, nurse midwives, anesthesiologists, radiologists and Care Coordinators. The Primary Contractor must notify Medicaid, in writing, of changes in the subcontractor base including the subcontractor's name, specialty, address, telephone number, fax number and Medicaid provider number.

7. Maintain a toll-free line and adequate staff to enroll recipients and provide program information. If the Primary Contractor, subcontractors and recipients are within the local calling distance area a toll-free line is not necessary.

8. Develop, implement and maintain an extensive recipient education plan covering subjects such as appropriate use of the medical care system, purpose of care coordination, healthy lifestyles, planning for baby, self-care, etc. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in Medicaid's efforts to promote the delivery of services in a culturally competent manner including those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight or speech impairments. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee.

9. Develop, implement, and maintain a provider education plan, covering subjects such as minimum program guidelines, billing issues, updates from Medicaid, etc. Provide support and assistance to subcontractors to include, at minimum, program guidelines, billing issues, updates from Medicaid, etc. This education shall be provided semi-annually. Documentation of provider education including, but not limited to, records of educational programs, including providers' attendance, date, length of session, topics covered, and presenter(s). Information shall be maintained for Administrative Audits.

10. Develop, implement and maintain an effective outreach plan to make providers, recipients and the community aware of the purpose of Medicaid Maternity Care Program and the services it offers. The Primary Contractor is refrained from marketing activities as specified in Administrative Code 560-X-37-.01(17). At a minimum such education shall be provided semi-annually. Documentation of providers, recipients and the community

outreach, including, but not limited to, attendance, date, length of session, type of outreach and information presented shall be maintained for Administrative Audits.

11. Develop, implement and maintain a recipient educational program explaining how to access the Maternity Care Program including service locations. Materials shall provide information about recipient rights and duties, provisions for after-hours and emergency care, referral policies, notification of change of benefits, procedures for appealing adverse decisions, procedures for changing Delivering Healthcare Professionals, exemption procedures and grievance procedures. The Primary Contractor must have the necessary staff and resources to address recipients with special needs such as hearing, sight or speech impairments. The Primary Contractor must inform all enrollees and potential enrollees who have special needs that the information is available in alternative formats. All materials shall be available in English and in the prevalent non-English language in the particular service area. The Primary Contractor is required to participate in Medicaid's efforts to promote the delivery of services in a culturally competent manner including those with limited English proficiency and with diverse cultural and ethnic backgrounds. The Primary Contractor must make oral interpretation services available for all non-English languages free of charge to each enrollee and potential enrollee. This applies to all non-English languages not just those that the State identifies as prevalent. Each entity must notify its enrollees that oral interpretation is available for any language and written information is available in prevalent languages and how to access those services. Documentation must support that requirements are met and must be maintained for Administrative Audits.

12. Develop, implement and maintain a grievance procedure including an appeal process, that is easily accessible and that is explained to recipients upon entry into the system. Documentation must support that requirements are met and must be maintained for Administrative Audits.

13. Develop a system to ensure that all written materials are drafted in an easily understood language and format. Written material must be available in alternative formats and in an appropriate manner that takes into consideration the special needs of those who, for example, are visually limited or have limited reading proficiency. All enrollees and potential enrollees must be informed that the information is available in alternative formats and how to access those formats. Documentation must support that requirements are met and must be maintained for Administrative Audits.

14. Develop, implement and maintain a system for handling billing inquiries from recipients and subcontractors so that inquiries are handled in a timely manner.

15. Develop, implement and maintain a computer based data system that collects, integrates, analyzes and compiles reports of recipient information.

16. Give Medicaid immediate notification, by telephone and followed in writing, of any action or suit filed and prompt notice of any claim made against the Primary Contractor by any subcontractor which may result in litigation related in any way to the subject matter of this Contract. In the event of the filing of a petition of bankruptcy by or against any subcontractor or the insolvency of any subcontractor, the Primary Contractor must ensure that all tasks related to any subcontractor are performed in accordance with the terms of the contract.

17. Ensure the subcontractor maintain for each recipient a complete record, including care coordination notes, at one location of all services provided. Such information shall be accessible to the Primary Contractor and shall contain such information from all providers of services identified by recipient name, recipient number, date of service, and services provided prior to making payment to that provider of service. Any record requested by the Primary Contractor shall be provided free of charge.

18. Medicaid will request copies of all medical record documentation from the Primary Contractor for medical record reviews and other quality related activities as applicable.

19. Perform claims reviews prior to submission to Medicaid for administrative review.

20. Advise recipients of services that may be covered by Medicaid that are not covered through the Maternity Care Program.

21. Promptly provide to Medicaid all information necessary for the reimbursement of outstanding claims in the event of insolvency.

22. Coordinate care from out-of-network providers to ensure that there is no added cost to the enrollee.

23. Must designate a person to enter data and manage Medicaid's Service Database entries for each District. This designee is responsible for the transmission of valid, timely, complete and comprehensive data, along with auditing the database periodically. The designated person shall evaluate data for quantitative integrity, such as variances compared to the eligibility system and Service Report omissions. Other responsibilities

include, but are not limited to, ensuring that all recipients, excluding exemptions, are entered into the database with all required reporting elements, and correcting discrepancies to ensure an error rate of no greater than 5%. This designee must attend mandatory training as required by the Alabama Medicaid Agency.

24. Must coordinate Service Database data entries for recipients transferring from one district to another district to ensure transmission of valid, timely, complete and comprehensive data entries.

C. General

1. The Primary Contractor is responsible for the management of comprehensive obstetrical care. The success of the Maternity Care Program is contingent upon the Primary Contractors' provision of a network of quality caregivers, which considers the needs of the enrollees and enables each pregnant woman served to receive comprehensive obstetrical care.

2. The Primary Contractor must utilize resources such as American College of Obstetrics and Gynecologists Standards (ACOG), established community practice standards, etc. in the development of program guidelines, which are reviewed and updated periodically as appropriate. The Primary Contractor must disseminate the program guidelines to all affected providers and upon request to enrollees and potential enrollees.

3. Primary Contractor must ensure that decisions for utilization management, enrollee education, and coverage of services are consistent with the program guidelines.

4. It is unlikely that a Primary Contractor will be able to provide all of the necessary resources to participate in the program. Subcontracts must be developed with other providers capable of providing the requisite services. Primary Contractors must have sufficient resources and personnel with necessary education and experience or training to perform the requisite duties and responsibilities.

5. The Primary Contractor must use the Alabama Medicaid Agency's Web Service Database for reporting program demographics and other elements related to the pregnancy.

D. Program Director

Each Maternity Care Primary Contractor must have a full time Director. This person shall have the following minimum_qualifications:

1. A BS or BA degree from an accredited college or, or a minimum of three years of management experience in a managed health care.

2. Experience in working with low-income populations.

The Program Director must have the authority to make day to day decisions, implement program policy, and oversee the provision of care to qualified recipients according to Federal and State regulations. Any changes in the Director's position must be approved by Medicaid. Medicaid must be notified in writing prior to the effective date of the change.

E. Computer System

Primary Contractors must maintain a HIPAA compliant computer system that collects, integrates, analyzes and reports. Minimum capabilities include:

1. Analysis of data and generation of reports including, but not limited to, utilization and financial services.

2. Database functionality that includes, but is not limited to, storage, analysis, and retrieval of information.

3. The ability to produce provider profiles including current overall recipient counts and the number of Medicaid recipients.

4. An automated tracking system that includes at a minimum the following information:

    a. Recipient name

    b. Medicaid number

    c. Date of birth

    d. Address

    e. Estimated Date of Confinement

    f. Telephone number

    g. Delivering Healthcare Professional Chosen

h. Care Coordinator Assigned

i. Risk status, including medical and psychosocial.

F. Provider Network

Primary Contractors must have a delivery system that meets Medicaid standards. Primary Contractors shall ensure that this delivery system promotes continuity of care and quality care. Primary Contractors must provide all medically necessary services as covered services following Medicaid policies and procedures. The Primary Contractor must:

1. Offer participation opportunities for the first 30 days prior to the contract start date and for the first month of each succeeding contract year to all interested potential subcontractors within district boundaries. Thereafter, a yearly open enrollment period is required during the first month of each succeeding contract year. Subcontractors must be willing to adhere to program requirements and accept offered reimbursement for services provided.

2. Offer all willing subcontractors the opportunity to participate at a reimbursement level consistent with other like subcontractors.

3. Have written policies and procedures for the selection and retention, credentialing and re-credentialing requirements and non-discrimination of subcontractors as specified at 42 CFR 438.214.

4. Not offer participation to potential subcontractors who do not agree to adhere to program requirements nor to those who have been disqualified from participation in any federal program, nor any person convicted of an offense involving Medicaid or Medicare programs.

5. Give equal and fair participation opportunities to providers who are willing to adhere to program requirements and who otherwise qualify. Complaints of discrimination will be investigated by Medicaid.

6. Contract with subcontractors who are geographically appropriate (50 miles) to recipients within the district. If there are no in-district providers that would ensure that every recipient meets the 50 miles requirement, the Primary Contractor is responsible for establishing a network of providers and may have to pursue contracts with out of district providers.

7. Continually monitor the provider network to ensure that the capacity is sufficient to meet the needs of all Medicaid recipients in the district and that availability and accessibility are not hindered.

8. Monitor and evaluate provider performance of all subcontractors to ensure that Medicaid and Primary Contractor standards are met. Such monitoring and evaluation system must include a corrective action system.

9. Notify Medicaid within one business day of any unexpected changes that would impair its provider network. This notification shall include:

    a. Information as to how the change shall affect the delivery of covered services, and

    b. Primary Contractor's plans for maintaining the quality of member care if the provider network change is likely to result in deficient delivery of covered services.

10. Not discriminate for the participation, reimbursement, or indemnification of any provider who is acting within the scope of his or her license or certification under applicable State law, solely on the basis of that license or certification. This includes providers that serve high-risk populations or specialize in conditions that require costly treatment. If a Primary Contractor declines to include individual or groups of providers in its network, it must give the affected providers written notice of the reason for its decision. This should not be construed to require the Primary Contractor to contract with providers beyond the number necessary to meet the needs of its enrollees, preclude the Primary Contractor from using different reimbursement amounts for different specialties or for different practitioners in the same specialty, or preclude the Primary Contractor from establishing measures that are designed to maintain quality of services, control costs and be consistent with its responsibilities to the enrollee.

11. Make a good faith effort to give a written notification of the termination of a contracted provider within fifteen days of the receipt or issuance of the termination notice to each recipient who was being seen on a regular basis by that subcontractor.

12. Give the Delivering Healthcare Professionals the option of establishing a limited number of Medicaid recipients that he/she shall accept.

G. Subcontractor Requirements

Subcontracts executed for the purposes of meeting program requirements must meet the following requirements:

1. Be in writing;

2. Require provider to comply with accepted medical Standards of Care;

3. Require provider to comply with other terms and conditions contained in this bid;

4. Contain provider reimbursement provisions;

5. Contain a provision specifying that provider must agree that under no circumstances (including, but not limited to, situations involving non-payment by the Primary Contractor, insolvency of the Primary Contractor, or breach of agreement) shall the provider bill, charge, seek compensation, remuneration or reimbursement from, or have recourse against Medicaid recipients, or persons acting on their behalf, for **covered** services, rendered during the term of provider's agreement or subcontract with the Primary Contractor. A provider may charge for non-covered services delivered on a fee-for-service basis to Medicaid recipients;

6. Contain a provision that states "payment for maternity-related services, not covered by the Maternity Care Program, does not make the recipient responsible for all of her maternity care";

7. Cover the same time period as the Primary Contractors' contract with Medicaid;

8. Contain a provision indicating that subcontracts may only be terminated for cause.

H. Annual Verification Requirements

The Primary Contractor must annually verify the following:

1. That the subcontractor possesses a current Alabama Medical License or certification and licensure as a Certified Nurse Midwife or other appropriate licensure requirements.

2. That the subcontractor is enrolled as a Medicaid provider.

3. That the subcontractor has current hospital privileges (as applicable), in good standing, at a Medicaid participating hospital within the Maternity Care Program district.

I. Monthly Verification Requirements

The Primary Contractor must monthly verify the following:

1. That the subcontractor or contractor is not currently debarred from participation from Medicare/Medicaid programs by checking the System for Award Management, formerly Excluded Party List System (EPLS).

2. That the subcontractor or contractor has not been excluded from participating in the Medicaid program by checking Medicaid's Exclusion List and documenting checks on Attachment Twenty-one, Exclusion List Check Form.

3. That the subcontractor or contractor has not been excluded from participating in the Medicaid program by checking the List of Excluded Individuals and Entities (LEIE) and documenting checks on Attachment Twenty-one, Exclusion List Check Form).

J. Outreach

The Primary Contractor is responsible for implementing and maintaining a Medicaid approved outreach program to inform and educate Medicaid recipients and the community on the Maternity Care Program's availability and services. The goal is to have all Medicaid eligible women enter care in their first trimester. The program components include, but are not limited to:

1. Medicaid approved printed material available at a sixth grade literacy level explaining program specifics. Outreach materials must include at a minimum explanations of how to access the Maternity Care Program. Medicaid must approve all outreach and educational material prior to actual usage. Review of the Primary Contractors' outreach materials will be done during the Administrative Audit.

2. Easily accessible program information available at sites such as hospitals, physician offices, Social Security offices, Department of Human Resources (DHR) offices, health departments, community resource centers, tax refund offices, family planning centers, or other community areas.

3. Coordination with local communities, other agencies, and service providers to ensure awareness of the program and to identify other services available to meet the needs of the Medicaid recipient.

4. A system for recipients to receive information and ask questions regarding the Maternity Care Program.

K. Recipient Education

The Primary Contractor is responsible for implementing and maintaining a

Medicaid approved education program to inform and educate Medicaid recipients on the Maternity Care Program. The program components include, but are not limited to:

1. Basic education, such as importance of early and continuous pregnancy care and the importance of following physician's instructions, and expectations of pregnancy and delivery.

2. Education regarding danger signs (e.g., spotting or bleeding, gush of fluid from vagina, etc.) during the pre and post natal period which includes information on when to seek medical care in an emergency situation.

3. Education on where and how to seek emergency care.

4. Education regarding nutrition and other components of a healthy lifestyle that are necessary for a good pregnancy outcome. Education regarding availability of newborn care classes, information about the Patient 1st Program and immunization schedules.

5. Education regarding importance of family planning along with written and oral instructions regarding all forms of birth control. The Plan First PT+3 materials are provided by Medicaid free of charge. The patient must also be made aware of and referred to the Plan First Program.

6. Discuss that over the counter and any other medicines must be approved by the Delivering Healthcare Professional, avoidance of smoking cigarettes, the availability of face-to-face Tobacco Cessation Counseling, products to assist with smoking cessation covered by Medicaid and the importance of avoiding use of drugs and alcohol.

L. Subcontractor Education

The Primary Contractor must provide a structured educational component for **each** subcontractor that participates in the program which includes, but is not limited to:

1. Program requirements

2. Billing procedures/claims resolution

3. Quality management protocols

4. Training sessions or provider meetings at least bi-annually or more often as needed to address problems and/or provide updated information

M. Billing Inquires/Claims Resolution

The Primary Contractor is responsible for implementing a system for responding to billing inquiries from recipients and subcontractors, and shall only refer claim inquiries to Medicaid that require an administrative review.

IV. ENROLLMENT REQUIREMENTS

A. Recipient Choice

Recipients must be allowed to select the Delivering Healthcare Professional of their choice at the time of entry (enrollment) into the care system. Primary Contractors must accept all women covered by the program and must not disenroll women from the program except through the exemption process (refer to Section V.E.). The Primary Contractor must comply with the requirements set forth at 42 CFR 438.56 regarding recipient disenrollment. If disenrollment is approved pursuant to Section V.E., the effective date of an approved disenrollment must be no later than the first day of the second month following the month in which the enrollee files the request. If the Primary Contractor fails to make a disenrollment determination within this timeframe, the disenrollment will not be approved.

Primary Contractor must have written policies and procedures governing recipient enrollment. The following guidelines apply:

B. List Requirements

1. A Delivering Healthcare Professional List must be available for use in the selection process.

2. Current Delivering Healthcare Professionals provider listings must be maintained. (NOTE: All listings, forms, etc. must be approved by the Agency prior to use).

    a. The list must include Delivering Healthcare Professional choices available through the provider network listed alphabetically and must be provided to the enrollees. The list shall include: address and telephone number, any physician extenders such as nurse midwives, nurse practitioners, residents in training, or physician assistants.

    b. Hospital where the Delivering Healthcare Professionals deliver, all sites where the Delivering Healthcare Professionals see recipients i.e., office, Health Department, satellite clinic, and all sites where prenatal care is provided.

c. Any limitations on services. For example, some Delivering Healthcare Professionals do not perform sterilizations. This would be significant if the recipient states that she wants sterilization prior to discharge from the hospital when the delivery occurs.

3. A weekly updated Delivering Healthcare Professional List is required during the initial award period and up to 30 days after implementation date and during the yearly open enrollment. Otherwise, the list shall be submitted as outlined in Section X.B., Records and Reports, Reporting Requirements.

C. Recipient Choice Requirements

1. The recipient is required to indicate on the 'Agreement to Receive Care/Release of Information Form' (Attachment Two) her choice of Delivering Healthcare Professionals and a copy of the form must be provided to her.

2. A recipient enrolled in the Patient 1st Program may select the same Primary Medical Provider (PMP) if he/she is a subcontractor for the Maternity Care Program.

3. A staffed toll-free line is required to enroll recipients into the Maternity Care Program and to provide requested information. The toll-free line must be staffed, at minimum, during the hours of 8 a.m.-5 p.m. weekdays with an answering machine for after hours.

4. All enrollment material must be provided in a manner and format that may be easily understood in compliance with 42 CFR 438.10(b) (1).

5. The recipient should be asked whether she is a Medicaid recipient. If not, ask if she submitted an eligibility application and whether she needs assistance to apply. If assistance is needed, an immediate referral to the Care Coordinator should be arranged to get the application process started.

D. Delivering Healthcare Professional Selection Process

Recipients must be advised of the process that is to be used in selecting a Delivering Healthcare Professional. This process shall include:

1. Recipient selects the Delivering Healthcare Professional of her choice for Maternity Care services from a list of network providers.

2. Inform, in writing, the medical professionals who shall be involved in her care, e.g. nurse midwives, nurse practitioners, on-call physicians, etc.

Patients may not in any way be influenced when selecting a Delivering Healthcare Professional.

3. If the Delivering Healthcare Professional has no slots available, staff must work with recipients to have a Delivering Healthcare Professional selected within two working days.

4. If the recipient does not want to choose a Delivering Healthcare Professional on the day of enrollment, then she shall be informed that she must call back within five working days to choose a Delivering Healthcare Professional, or the Primary Contractor shall assign a Delivering Healthcare Professional to her on a rotation basis between other Delivering Healthcare Professionals listed on the panel. Recipients shall also be notified of the Delivering Healthcare Professional with whom they have been assigned.

5. In the event the recipient refuses to choose a Delivering Healthcare Professional or fails to choose a Delivering Healthcare Professional within the designated time frame, the Primary Contractor must assign her to a Delivering Healthcare Professional based on equivalent distribution among the Delivering Healthcare Professionals, with available openings to serve additional recipients. This process must include consideration of the distance the recipient lives from the provider and prior relationships, if the Primary Contractor has access to this information.

E. Delivering Healthcare Professional Notification

1. Each recipient's selected Delivering Healthcare Professional must be notified within five working days of the recipient's enrollment.

2. A monthly listing of Medicaid recipients electing to enroll with each Delivering Healthcare Professional shall be provided to the Delivering Healthcare Professional. This list must be provided prior to the first day of each month.

F. Changes in Selection of Delivering Healthcare Professionals

Guidelines for change of Delivering Healthcare Professional must include:

1. Allowing recipient to change Delivering Healthcare Professionals, without cause, once within the first 90 days of enrolling.

2. Establishing internal policies and procedures for changing Delivering Healthcare Professionals.

3. Allowing recipient to change Delivering Healthcare Professionals after the first 90 days with cause, which is defined as a valid complaint submitted to the Primary Contractor in writing explaining the reason the recipient wishes to change her Delivering Healthcare Professional.

4. Tracking of changes in Delivering Healthcare Professionals with grievance procedure time frames being met.

G. Program Enrollment

Enrollment is defined as the date that the Agreement to Receive Prenatal Care form is signed by the recipient. If the delivery has already occurred there is no reason to enroll the recipient. The following guidelines apply when processing a woman's enrollment into the program:

1. Recipients must be provided with all required information regarding rights and responsibilities, grievance process and fair hearing process, and appropriate telephone numbers, at the time of enrollment.

2. The person enrolling the recipient into the program must ascertain if the woman has third party liability. If TPL is available, obtain the name of the insurance company, the name on the policy (name of insured), recipient relationship to the insured, address, phone number and policy number. If possible, ascertain from the recipient what type of coverage the policy provides. Verify the information with the insurance company or Medicaid and record all information in the file. Some of this information may be available through the online eligibility systems maintained by Medicaid's Fiscal Agent. The recipient should be informed of coverage limits of pregnancy related illness through MAGI and allowed to make an informed choice regarding continued coverage of any previous insurance coverage. **It is vital that this type of information be collected at the beginning of prenatal care.**

3. Advise the recipient of her ability to change Delivering Healthcare Professional, without cause, within 90 days of enrollment, or at any time with cause. Continuity of care shall be stressed at the time of enrollment to encourage the recipient to select a Delivering Healthcare Professional with whom she is comfortable.

V. SERVICES

A. General

1. All maternity care services offered under the contract must be in an amount, duration, and scope that is no less than the amount, duration, and scope for the same services furnished to recipients under fee-for-service

Medicaid. The Primary Contractor may not arbitrarily deny or reduce these services for any reason including the diagnosis, health status, type of illness, or condition. The Primary Contractor may place appropriate limits on a service on the basis of criteria such as medical necessity, or for utilization control, provided the services furnished can be expected to achieve their purpose as defined in 42 CFR 438.210(a).

2. The Alabama Medicaid Administrative Code Rule 560-X-1-.07 states: "Providers who agree to accept Medicaid payment shall agree to do so for all medically necessary services rendered during a particular visit. For example, if pain management services are provided to Medicaid recipients during labor and delivery, these services are considered by Medicaid to be medically necessary when provided in accordance with accepted standards of medical care in the community. These services are covered by, and billable to Medicaid. Providers may not bill Medicaid recipients they have accepted as recipients for covered labor and delivery related pain management services."

3. The Primary Contractor shall require that provisions be made available for a second opinion (if either the recipient or health care professional deems it necessary) from a qualified health care professional within the network, or arrange for a second opinion outside the network at no cost to the recipient as specified in 42 CFR 438.206(b)(3) and (4).

4. Out of network providers must coordinate with the Primary Contractor with respect to payment as specified in 42 CFR 438.206(b)(5).

5. Enrollees with special needs shall be allowed direct access to specialists as specified in 42 CFR 438.208(c) (4).

6. The Primary Contractor must have a mechanism in place to assess each Medicaid enrollee identified for special health care needs in order to identify any ongoing special conditions of the enrollee that require a course of treatment or regular monitoring. The assessment must use appropriate health care professionals. The Primary Contractor must maintain a treatment plan for enrollees determined as having special care needs. The treatment plan must be developed by the enrollee's primary care provider with enrollee participation, and in consultation with any specialists caring for the enrollee and must be reviewed and approved by the Primary Contractor within a timely manner. The treatment plan must be developed in accordance with applicable quality assurance and utilization review standards.

7. Recipients must use in-network providers.

B. Services Included in the Global Fee

1. The Primary Contractor will be responsible for implementation and coordination of a comprehensive maternity care delivery system with the exception of the inpatient hospital component that meets the needs of the Medicaid recipients. The time span of responsibility begins the date that pregnancy is determined and ends the last day of the month in which the 60th postpartum day falls.

2. Primary Contractors and their Delivering Healthcare Professionals are responsible for identification and referral of high risk recipients to the appropriate high risk referral site or appropriate high risk physician.

3. The fee shall include all usual prenatal services appropriate to the risk level of the woman including the initial visit at the time pregnancy is diagnosed.

4. Covered services must be medically necessary and encompass maternity related services as well as those that might otherwise complicate or exacerbate the pregnancy.

5. The Primary Contractor shall receive a fee upon pregnancy outcome (delivery or termination by miscarriage or stillbirth at 21 weeks or later).

6. Fees paid by Medicaid to the Primary Contractor represent payment in full.

7. Recipients cannot be billed for any service that is included in the Maternity Care Program.

8. Chapter 28 of the Alabama Medicaid Provider Manual provides additional details on the billing of services.

9. Services to be provided through the Primary Contractor network and which are reimbursed as part of the global are listed in Attachment Three and described below. If there is a question as to whether a service is covered, please contact the Alabama Medicaid Agency for verification and clarification.

    a. Prenatal Visits

    Visits to the Delivering Healthcare Professional include the initial prenatal visit as well as any subsequent visits. The components of the initial prenatal visit and any subsequent visits are defined by ACOG.

    b. Ultrasounds

    Maternity ultrasounds are unlimited in number and are a component

of the global fee. The global fee includes both the professional and technical components of **all** medically necessary ultrasounds. A Primary Contractor may develop an evidence-based prior authorization process to manage the number of ultrasounds performed. **Note: The professional component of ultrasounds performed in an outpatient setting is included in the global fee.**

c. Delivery
The global fee includes vaginal delivery or cesarean section delivery. No more than one fee may be billed for a multiple birth delivery.

d. Postpartum
Postpartum care includes inpatient hospital visits, office visits and home visits following delivery for postpartum care through the end of the month of the 60-day postpartum period. The postpartum Delivering Healthcare Professional exam shall be accomplished by the 60th day after delivery.

e. Assistant Surgeon Fees
The global fee includes assistant surgeon fees for cesarean-section deliveries.

f. Associated Services
The global fee includes identified services associated with treatment of the pregnancy during the antenatal delivery and postpartum period listed in Attachment Three.

g. Laboratory Fees
The global fee includes routine chemical urinalysis, hemoglobin and hematocrit tests as listed in Attachment Three. Other laboratory tests may be billed to Medicaid's fiscal agent fee-for-service. **EXCEPTION: urinalysis, hemoglobin and hematocrit provided in conjunction with an emergency room visit are billable fee-for-service.**

h. Anesthesia Services
The global fee includes anesthesia services, performed by either an anesthesiologist, nurse anesthetist, or the Delivering Healthcare Professional, which are not medically contraindicated. The Primary Contractor shall provide for payment of anesthesia for Medicaid recipients to the same extent and under the same conditions as available to the general public. Attachment Three lists the anesthesia codes which are included in the global fee.

i. Care Coordination Services
The global fee includes Care Coordination which is detailed in

Section VI.

j. Postpartum Home Visit
Home visits are optional. It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. Refer to Section VII for specific details related to home visits.

C. Excluded Services—Covered Fee-For-Service

A general description of those services outside the scope of the global fee is listed below. For these services, the provider of service shall bill using the appropriate CPT code and their regular provider Medicaid number. All claims for these services shall be sent directly to Medicaid's Fiscal Agent and include, but are not limited to:

1. Inpatient Hospital Care
All hospital care will be billed fee for service and will include applicable limitations of 16 inpatient days per calendar year.

2. Drugs
Medications prescribed for a pregnant woman are covered if the drug is covered through the Medicaid Pharmacy Program. The medication must be prescribed by the Delivering Healthcare Professional or specialty physician and presented to an active Medicaid pharmacy provider. The prescribed drug will be subject to all applicable Medicaid policies. Pharmacy providers should dispense the drug at no cost to the recipient.

3. Durable Medical Equipment/Supplies
Pregnant women with Type I, Type II or gestational diabetes are eligible to receive diabetic equipment/supplies from an active Medicaid Equipment (DME) Supplier. Not all pharmacies are DME suppliers. In order to locate a DME supplier, you may contact the Clinical Services and Support Division at 334-242-5050 or by accessing the following link: http://www.medicaid.alabama.gov/documents/4.0_Programs/4.3_LTC_Services/4.3.3_Other_LTC_Programs/4.3.3.1_DME/4.3.3.1_DME_Providers_Revised_5-1-14.pdf .

4. Lab Services
All lab services except hemoglobin, hematocrit, and chemical urinalysis may be billed fee-for-service. Pregnancy tests can be billed fee-for-service.

5. Radiology
Refer to the Global Associated Codes for radiology services which are covered in the global fee.

6. Dental

Dental services are covered for eligible recipients certified as children under age 21.

7. Physician
   Physician fees for family planning procedures, circumcision code, routine newborn care code, standby and infant resuscitation code may be billed fee for service. Claims for circumcision, routine newborn care, standby and infant resuscitation may be billed under the mother's name and number.

8. Family Planning Services
   Claims for physician services with a family planning procedure code or indicator may be billed fee-for- service.

9. Face-to-Face Tobacco Cessation Counseling, including referrals to the Quitline and medications to assist applicable recipients with smoking cessation efforts.

10. Outpatient Emergency Room Services
    Outpatient emergency room service claims containing a facility fee charge of 99281-99285 and associated physician charges 99281–99288, may be billed fee-for-service. This includes outpatient observation. The Maternity Care Program does not restrict access to emergency services.

11. Transportation
    Transportation as allowed by Medicaid's State Plan may be billed fee for service. The Medicaid Non Emergency Transportation (NET) Program covers non-emergency transportation.

12. Fees for Dropout/Miscarriages

    a. Claims for miscarriages must include the appropriate diagnosis code from the following range, 630-635, 637-639. Claims using these diagnosis codes may be billed directly to Hewlett Packard.

    b. If a woman begins care with any district's program, and subsequently moves out of district or miscarries (prior to 21 weeks), she is considered a dropout.

    c. The Primary Contractor shall be paid a dropout fee for recipients that have a miscarriage prior to 21 weeks gestation.

    d. Services for drop-outs may be billed fee-for-service.

    e. In order for the claims to process for a dropout, subcontractors must send all claims to the Primary Contractor. The Primary Contractor

must complete the Administrative Review Form and forward the claims to Medicaid for action.

f. The Primary Contractor can bill the dropout fee directly to Hewlett-Packard (Medicaid's fiscal agent liaison).

13. Mental Health
Visits for the purpose of **outpatient** mental health services may be billed fee for service. Screening, Brief Intervention and Referral to Treatment (SBIRT) codes for pregnant women may be billed by Delivering Healthcare Professionals who have completed a training program and have had a specialty provider indicator added to the provider file. These services include alcohol and/or drug screening and/or brief intervention.

14. Referral to Specialists
Office or in-hospital visits provided by non-OB specialty physicians for problems complicated or exacerbated by pregnancy may be billed fee-for-service.

15. Program Exemptions
Claims for women who are granted a program exemption may be billed fee-for-service. Refer to Section E for details on the exemption process.

16. Non-Pregnancy Related Care
Services provided that are not pregnancy-related are the responsibility of the recipient unless she is eligible for regular Medicaid benefits.

17. High Risk Maternity Care Services Provided by a Teaching Physician As defined in State Plan AL-11-022, 4.19-B, Attachment Thirty, the reimbursement for provision of high risk maternity care services provided by a teaching physician as defined in State Plan AL-11-022, 4.19-B, which states in whole or in part " Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds" is excluded from the global and may be billed fee-for-service.

18. High Risk Maternity Care Services Provided by a Medicaid Enrolled Board Certified Perinatalogist-the reimbursement for provision of high risk maternity care services provided by a Medicaid enrolled Board Certified Perinatalogist is excluded from the global and may be billed fee-for-service. **All routine maternity care services are subject to the Maternity**

District's Plan. The Perinatalogist must subcontract with a Primary Contractor for routine maternity care services. Reimbursement for provision of routine maternity care services will be through the global payment methodology according to contractor-subcontractor agreement.

19. Routine Maternity Care Services Provided by a Primary Contractor and/or Delivering Healthcare Professional to an Enrolled Recipient Before and After Transferring to a Medicaid Enrolled Teaching Physician or Medicaid Enrolled Board Certified Perinatalogist -the reimbursement for provision of routine maternity care services provided by a Primary Contractor and/or Delivering Healthcare Professional to an enrolled recipient before and after transferring to a Medicaid enrolled teaching physician as defined in Section 4.19-B of the State Plan which states in whole or in part " Teaching physicians are defined as doctors of medicine or osteopathy employed by or under contract with (a) a medical school that is part of the public university system (The University of Alabama at Birmingham and The University of South Alabama) or (b) a children's hospital healthcare system which meets the criteria and receives funding under Section 340E (a) of the U.S. Public Health Service Act (42 USC 256e), and which operates and maintains a state license for specialty pediatric beds" or a Medicaid Enrolled Board Certified Perinatalogist for high risk care will be reimbursed fee-for-service and will not be reimbursed through the global payment methodology. Reference Section VIII Payment for Service for additional information.

D. Referrals for High-Risk Care

1. Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Healthcare Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

2. Primary Contractor must clearly describe the way the program will manage high-risk pregnancies, including a process for identifying high-risk cases, a method to denote high-risk status and the reason for high risk-status, a network for care, policy and procedures for monitoring referrals and services to be provided to high-risk women.

3. High risk maternity services by a Board Certified Perinatalogist must be coordinated with the Primary Contractor.

E. Program Exemptions

1. Purpose

The purpose of the program exemption is to allow recipients to receive care outside of their established Maternity Care districts. There must be policies and procedures developed by the Primary Contractor describing how the exemption will be handled including application of criteria. The Primary Contractor cannot request disenrollment because of a change in the enrollee's health status, or because of the enrollee's utilization of medical services, diminished mental capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the entity's ability to furnish services to either this particular enrollee or other enrollees). A Maternity Care Program Exemption Request Form (Attachment Thirteen) must be completed and submitted to the Alabama Medicaid Agency for approval. Medical exemptions will not be granted under the Maternity Care Program.

a. Medicaid Eligibility Granted Late in Pregnancy
When the recipient applies for and receives Medicaid eligibility late in her pregnancy (third trimester which begins at 27 weeks gestation through delivery) or after delivery and has been receiving continuous care through a non-subcontracted provider, she may be eligible for a program exemption. The Primary Contractor must maintain documentation demonstrating a significant and unexpected financial change occurring after 27 weeks (e.g. loss of insurance or loss of job). The Primary Contractor must confirm the date of application.

b. Private Managed Care/HMO
If a recipient has insurance or a managed care plan, the Primary Contractor must maintain a copy of the policy or a letter from the insurer indicating the scope of coverage or that the recipient must use a prescribed provider network.

F. Services for Non-citizens

Services provided to Non-citizens are not part of the Maternity Care Program. The following is provided for information only: "Certification is done through the Medicaid out-stationed eligibility worker. Only the actual provider of service is reimbursed in these cases. For a pregnant woman, only the delivery is covered. If you are contacted by a Non-citizen, or someone who is helping a Non-citizen, refer them to the out-stationed eligibility worker. All payments for this eligibility category are processed outside the Maternity Care Program

through emergency services."

VI. CARE COORDINATION

A. Overview

An integral part of the medical care delivered through the Maternity Care Program is Care Coordination. Care Coordination is the mechanism for linking and coordinating segments of a service delivery system to ensure the most comprehensive program meeting the clients' needs for care. It may involve one person or a team that has responsibility for managing, assessing, planning, procuring or delivering, monitoring and evaluating services to meet the identified needs of the client. The approach to Care Coordination shall vary from case to case. The needs of the patient should dictate when services are provided and the number of visits that are needed.

1. Care Coordination can be generally defined in one of three ways:

    a. A system of activities to link the service system to a recipient;

    b. A balanced system of services; or

    c. A process of ensuring that the recipient moves sequentially through a continuum of services.

2. Stratification of Case Management

    a. Visit flexibility to meet the needs of the recipient is allowed. Minimums are established, but, beyond the minimum, the total number of visits should be dictated by the needs of the patient. The Care Coordinator will be required to assess the patient face to face at a minimum of two visits. The Care Coordinator will have flexibility to determine how to best improve outcomes.

    b. If the medical or psychosocial status of the recipient changes, the Care Coordinator is responsible for adjusting the service plan and proceeding accordingly.

    c. It is up to the Delivering Healthcare Professional and Care Coordinator to decide and develop a service plan that meets the patient's needs.

B. Requirements for Maternity Care Coordinators

1. Social workers licensed and/or license-eligible for Alabama practice with a BSW or an MSW from a school accredited by the Council on Social Work Education. License-eligible social worker(s) must obtain license within12 months of date of employment to function as a Care Coordinator.

2. Registered Nurses, licensed by the Alabama Board of Nursing, with a minimum of one year experience in care coordination, accessing resources, and coordinating care with low-income populations; or, if no care coordination experience, completion of a Care Coordinator training course provided by the Primary Contractor and supervision by an experienced Care Coordinator for at least six months. Documentation must support the Care Coordinator's training has been completed and supervision for the specified period was provided. Compliance with this requirement will be reviewed during the Administrative Audit.
3. Licensed Practical Nurse(s), licensed by the Alabama Board of Nurses, with at least two years of clinical experience and one year experience in care coordination, accessing resources and coordinating care with low-income populations.
4. The Primary Contractor has flexibility in determining how to perform the Application Assister function. Care coordinators are not required to be Application Assisters; however, the Application Assister function is required to be performed by the Primary Contractor. The Primary Contractor may choose to use a Care Coordinator for this function, while others may choose to have other staff provide this function. Application Assister training is provided free of charge by the Alabama Medicaid Agency staff (Attachment Six). The Contractor shall have an individual (s) designated as a trainer for the Train-the Trainer program. The designee must attend the Train-the-Trainer class and provide certification training to Application Assisters as deemed necessary in order to maintain compliance with certification and re-certification requirements. The certification period for Application Assisters and Train-the-Trainer designee is every two years.

5. Care Coordination is a professional skill and must be supported from within the Primary Contractor system. Skills and functions employed by the Care Coordinator include, but are not limited to:

    a. Performing the initial encounter requirements, performing the psychosocial risk assessment, assessing the medical and social needs, developing service plans, providing information and education, making all appropriate referrals (including Plan First and CoIIN referrals), and tracking recipients throughout their pregnancy and postpartum period.

    b. Community orientations, including the ability to locate, augment, and develop resources including information on services offered by other agencies.

c. The Primary Contractor must advise all subcontractors of Care Coordinators services and must require that the subcontractors refer all Medicaid recipients to enroll in the program with the Primary Contractor within ten days of the first visit.

d. The Care Coordinator shall provide the recipient with a business card that provides location and telephone number of the Care Coordinator should any questions arise.

e. Care Coordinators must be located in an area which provides adequate recipient access and maintains recipient confidentiality. Private offices are preferred.

f. Telephones must be available for use in recipient contacts.

g. Primary Contractor must have a training plan for initial and on-going care coordination. These plans must at a minimum support the requirements of this document and include training specific to the maternity program and/or related topics on an on-going basis. Educational materials must include obtaining TPL information, the importance of keeping appointments with both the Care Coordinator and the DHCP, exemption candidates, current proper sleeping positions for the infant, domestic abuse, breast feeding, smoking & alcohol or other substance cessation, nutrition, and bonding for mother and infant. The effectiveness of the training plans will be monitored per quality outcome measures.

h. Care Coordinators or other Primary Contractor staff will enroll the recipient in the Maternity Care Program and start the Medicaid application process.

i. Primary Contractor must have a system for verification of current license for each Care Coordinator. Verification of current licensure will be checked during the Administrative Audit.

C. Initial Encounter

Time frame: entry into care

- ✓ Enrolled 0-6 weeks gestation - this encounter should be no later than 21 days after enrollment date
- ✓ Enrolled 7-14 weeks gestation - this encounter should be no later than 14 days after enrollment date.
- ✓ Enrolled 15 weeks gestation or more - this encounter should be no later than 7 days after enrollment date.

1. Intake form- The Care Coordinator will prepare the intake form for enrollment into the Maternity Care Program. Minimum elements to be included on the intake form of your choice are: Recipient Name; Date of Birth; Address; County of Residence; Social Security Number; Medicaid Number if they have

one; if the recipient has no Medicaid number make a note to assist with application as appropriate; Delivering Healthcare Professional choice; Date Delivering Healthcare Professional notified; and psychosocial risk status. A sample form is included as Attachment Twenty-six. This form will be faxed to the office of the Delivering Healthcare Professional of choice within five calendar days of the recipient's first Delivering Healthcare Professional's health visit. If the recipient does not have Medicaid financial eligibility, the Primary Contractor is responsible for immediately providing Application Assister services to aid the patient in completing the application process.

2. The following forms must be completed at the initial encounter:

    a. Psychosocial/medical risk assessment

    b. Agreement to Receive Care/Release of Information (Attachment Two)

    c. Recipient Rights and Duties as described in Attachment Eight and required by 42 CFR 438.100

    d. Maternity Care Program Fact Sheet (Attachment Five)

    e. Maternity Care Program Smoking Cessation Form (Attachment Fourteen)

3. Information about facility location, hours of operation, services available, etc. should be shared. Explain your role as Care Coordinator and how you will be assisting the recipient during her pregnancy and postpartum period. Encourage the recipient to contact you as needed for assistance.

4. Explain the benefits and services provided through the Maternity Care Program. Explain that all pregnancy related care including prenatal, delivery and postpartum is available through the Primary Contractor network. Stress the importance of pre-natal and postpartum visits. Stress that birth control is frequently arranged at the postpartum visit. Explain that Medicaid also offers assistance with transportation to medical appointments, emergency ambulance coverage, family planning and pediatric services.

5. Provide written and oral education about the grievance process and explain how it is designed for her. Ensure that the recipient understands the process and the procedures for filing a grievance, an appeal and/or fair hearing.

6. Explain the importance of early and continuous prenatal care. Help her understand that she can play a key role in shaping the birth outcome.

Explain that if she encounters barriers such as transportation, medication, childcare, etc., she should contact the Care Coordinator for assistance.

7. Develop and document a service plan for coordinating total obstetrical care based on medical and psychosocial risk status that will best suit the needs of the recipient.

8. Screen the patient for partner abuse utilizing the screening tool in Attachment Nine. Be cognizant of verbal and non-verbal clues when assessing the patient.

9. Encourage breast feeding. Explain the benefits such as better infant tolerance, better immunity from childhood viruses and illnesses. Explain that pumping can be done and the milk stored for times when the mother will be away, and that nursing the infant, avoiding any artificial nipples, will produce more mother's milk. The Care Coordinator should utilize the most effective teaching methods for increasing the rate of breast feeding.

10. Explain that the recipient may be receiving a home visit. Inform her of the positive aspects of the visit and what can be accomplished.

11. Ask if the recipient is a smoker. Encourage smoking cessation. Discuss the effects of smoking on the infant to include: increased risk of prematurity, low birth weight, infant mortality, and a sicker infant. Use the most effective evidence-based method suitable to your area to assist moms to stop smoking. Encourage the use of the Alabama Department of Public Health Quitline for counseling and assist with the referral process, educate the recipient of available face to face counseling sessions, and ask her to discuss with her doctor the possibility of obtaining a prescription to help her stop smoking.

D. Subsequent Encounters

Care Coordinators will be required to assess the recipient face to face at a minimum of two encounters. One of the required encounters is the Initial Encounter defined above. The other encounter must occur while the mother is still in the hospital after delivery. Other encounters will be at the discretion of the Care Coordinator based on the level of complexity of the recipient needs, either medical or psychosocial. The encounters should be scheduled in order to help obtain the best outcomes.

1. Update the psychosocial assessment and service plan based on client interview and any other available information.

2. Encourage continuous compliance with prenatal care, reviewing the recipient's medical high-risk factors and explaining the importance of continued prenatal care.

3. Assess for understanding of medical conditions as well as the plan for managing them as outlined by medical staff. Assist in arranging further counseling by medical staff as needed.

4. Provide the recipient with the information about the various family planning services available. Counsel on the effects of each method and assist the recipient with consent forms as appropriate.

5. Ask about status of Medicaid eligibility. Assist with resolving the delay of approval, if possible.

6. Screen the patient for partner abuse utilizing the screening tool in Attachment Nine. Be cognizant of verbal and non-verbal clues when assessing the patient.

7. Determine the need for any third party exemptions.

8. Ensure that the recipient knows which hospital will be used for delivery. If Medicaid coverage is established, complete hospital preadmission for the hospital of choice.

9. Discuss the labor and delivery process. Begin talking with the recipient about what to expect and what to do at the onset of labor, etc.

10. Re-emphasize and encourage breast feeding.

11. Explain that the patient may meet the criteria for a home visit. Re-emphasize the purpose and the positive aspects.

12. Review smoking cessation with women who smoke. Utilize the most appropriate evidence based methods. Encourage to cut down and quit. Explain harmful effects to the fetus. If she states that she has quit or cut down on the number of cigarettes that she smokes, praise her efforts. Reference the Definition Section for the meaning of "Smoker".

13. Ask the recipient if she has considered who will provide pediatric care. If needed provide a list of Medicaid pediatric care providers. If she has not thought about a pediatric care provider, encourage her to do so. Provide information and services available for the newborn through the first year of life including Medicaid Patient 1st and EPSDT (Early Periodic Screening and Developmental Testing). Assist the patient in completing the Patient 1st Newborn Assignment Choice Form (Attachment Eleven). A copy of the

hospital information and the Medicaid Patient 1st Newborn Choice Form should be faxed to the selected health care professional at the time of the hospital visit.

14. Ensure that the patient is prepared for childbirth. If preadmission has not been completed, assist recipient in choosing hospital for delivery and completing preadmission. Assess transportation needs to the scheduled hospital.

15. Ensure home preparation, assistance with newborn and mother in immediate postpartum period, availability of an infant car seat, etc.

16. Verify that the recipient and father of the baby (if he is involved) have made preparations for the infant's arrival and that they have a bed and a space designated for the new infant.

17. Educate the recipient regarding SIDS and current methods of placement of the infant for sleep.

18. Explain to the recipient the need to contact the eligibility outstation worker/DHR worker/Social Security worker with information about the baby's birth to ensure a Medicaid number for the baby.

19. Explain to the recipient that in cases of early hospital discharge where the Care Coordinator or designee does not get to visit with her in the hospital, **a home visit will be made.** Explain the need for the visit and what services will be offered. Encourage the recipient to use this time for education.

20. Emphasize the importance of keeping the post-partum Delivering Healthcare Professional check-up appointment. If it has not been scheduled then screen for any barriers, e.g. transportation, childcare, etc. Assist the recipient as necessary in scheduling the postpartum exam.

21. Explain to the recipient that you or someone from the Primary Contractor's staff will make a visit to the recipient during the hospitalization after delivery.

22. Re-emphasize the positive aspects of the home visit if it is determined by the Care Coordinator that a home visit is necessary. Obtain phone numbers where the recipient may be contacted. Ask where she will be staying when she takes the infant home from the hospital. Assure her that this visit is to help her in caring for herself and the infant.

23. Stress the importance of preventive dental care for the infant. Utilize Medicaid's Smile Alabama educational material available via Medicaid's website.

24. Review the importance of effective family planning methods and availability of family planning services. Verify that the recipient has chosen birth control pills or any other method (condoms, injection contraception, etc.) of family planning and explain that this must be discussed with the Delivering Healthcare Professional during the hospitalization. A prescription may be necessary in order to obtain the chosen method. Explain the option of having a Long Acting Reversible Contraceptive implanted in the hospital immediately after delivery or in an outpatient setting immediately after discharge from an inpatient setting.

25. Make referrals, including, but not limited to, Plan First and Patient 1st Programs, and CoIIN if applicable.

26. Emphasize that the recipient can become pregnant while breast feeding if she is not using any contraception.

E. Missed Encounters/Attempts

If the inpatient hospital encounter is missed, a home visit must be completed. At least two attempts must be made to complete the missed encounter. All home visits or attempts must be completed within 20 days of the delivery date. Missed attempts must be **documented** in the recipient's medical record.

F. Tracking of Care Coordinator Visits

In an effort to ensure standard tracking of Care Coordination services provided, the following codes have been established for use by the Primary Contractor for internal tracking. **These codes cannot be billed separately to Medicaid.**

T1016 - U1	1ST encounter
T1016 – U2	2ND encounter
T1016 – U3	3RD encounter
T1016 – U4	4TH encounter
T1016 – U5	5TH encounter

G. Oversight of Care Coordinator Activities

Primary Contractor has the responsibility of maintaining oversight activities regarding the provision of Care Coordination services.

VII. HOME VISITS

A. Purpose

Home visits are optional, unless the required visit in the hospital is missed. **If the hospital face to face encounter visit is missed, a home visit must be made within twenty days of the delivery date.** It is the opinion of the Alabama Medicaid Agency that home visits improve outcomes. The Primary Contractor may develop criteria within their respective district for the purpose of home visits. The home visit criteria must be submitted for review by the Medicaid Agency with the ITB response.

The following are recommendations for consideration of home visit criteria development.

1. Under 16 Years of Age
   - At time of conception
   - Late entry into care (20 weeks gestation and over)
   - Not residing in home with parents or significant other
   - Grossly overweight or underweight
   - Not in school
   - Use of tobacco and/or alcohol and/or drugs
   - Transportation issues
   - Lack of support from family or father of baby
   - Any triggers that indicate a need for follow-up after delivery

2. Drug and Alcohol Abuse
   - Self reported
   - Psychosocial assessment
   - Odor of alcohol
   - Observations of track marks and/or bruises from needle use
   - Unexplained late entry into care 20 weeks gestation and over
   - At risk lifestyle (i.e., multiple sex partners)
   - Suspicious behavior such as incessant talking, drug seeking behavior (i.e., narcotics for various pains) glazed eyes, lying, sedated, short attention span, etc.

3. Mental illness
   - Postpartum depression (it is expected that these women may require a series of visits)
   - Long term history of mental illness
   - Taking psychotropic drugs for mental illness (ex. Mellaril, Haldol, Lithium, etc.)
   - Taking anti-depressants and exhibiting outward signs of depression (i.e., flat affect depressed mood and thought process, lack of interest in personal appearance, lack of interest in planning for baby's arrival, etc.)

4. Birth weight 2500 grams or less
   - Lack of prenatal care
   - Previous birth outcomes including low birth weight births
   - Mom or others in the household are smokers
   - Whether the infant is enrolled in a hospital follow-up program

5. Partner Abuse (Attachment Nine)
   - Reported by the recipient
   - Unexplained visible injuries
   - Fear of partner & his uncontrollable temper
   - Reports of partner's threats to harm or kill recipient
   - Reports of extreme partner jealousy and/or being possessive
   - Reports of verbal abuse; yelling, cursing, name-calling, isolation
   - Other—Care Coordinator or Delivering Heath Care Professional judgment

B. Documentation

Medical records must be maintained that support the need or lack of need and the outcome of home visits. Refer to Attachment Seven.

C. Tracking Of Home Visits

The following codes have been established to assist the Primary Contractor in tracking home visits. These are not separately billable codes but codes to be used for internal tracking systems and may be expanded dependent upon your district specific criteria.

H001 – under 16 years of age
H002 – Drug & Alcohol Abuse
H003 – Mental Illness
H004 – Low Birth-weight
H005 – Partner Abuse
H006 – Missed Inpatient Encounter
H007 – Other

VIII. PAYMENT OF SERVICES

A. Global Fee

The following procedure codes must be billed when the enrolled recipient has received **total** obstetrical care through your program. Only with sufficient documentation that the women have received care as listed in **59400** and **59510 by the delivering healthcare professional** will the full global fee be

paid. For women who present for delivery only services, Primary Contractors are to bill the delivery only global fee.

Global fee codes to be used are:

59400 – Routine obstetric care including antepartum care, vaginal delivery (with or without episiotomy, and/or forceps) and postpartum care.
59510 – Routine obstetric care including antepartum care, cesarean delivery and postpartum care.

Delivery Only Services

For recipients who receive **no prenatal care** through the Primary Contractor's network, a Delivery-Only fee must be billed. The components of the Delivery-Only fee include those services provided from the time of delivery through the postpartum period including all the required encounters by the Care Coordinator. The reimbursement amount for a Delivery-Only is 80% of the global fee. This payment represents payment for those services occurring at delivery and postpartum.

The following Delivery-Only procedure codes must be used to bill Delivery-Only services:

59410 – Vaginal Delivery and Postpartum Care Only
59515 - Cesarean Delivery and Postpartum Care Only

Note:
The Global Fee Codes listed above must have one of the following modifiers appended:
UD Medically necessary delivery prior to 39 weeks of gestation
U9 Delivery at 39 weeks of gestation or later
UC Non-medically necessary delivery prior to 39 weeks of gestation

Claims that are submitted for deliveries without one of the required modifiers will be denied.

B. Dropout Fee

This fee must be billed when the recipient begins care in your program but does not deliver. In order to bill this service the woman must have been enrolled prior to delivery. The procedure code is **99199.**

C. Subcontractor Reimbursement

The Primary Contractor must have a HIPAA- compliant automated

reimbursement system for payments to subcontractors and out-of-plan providers. **Payments to subcontractors should be made within 20 calendar days of Medicaid payment and in all cases within 60 calendar days of date of delivery. Payments to out-of-plan providers must be made within 90 calendar days.** The only exception is when TPL is involved or when payment is under appeal. Medicaid payment is defined as the date the check-write is deposited in to the provider's account.

Delivering Healthcare Professionals, except those associated with a teaching facility as defined in Attachment Thirty, 4.19-B of the State plan, must be paid at a rate no less than the Medicaid fee-for-service urban rate for delivery only. Effective October 1, 2014 the current urban fee-for-service rate is $1,000 for delivery only. Nurse midwives are paid at 80% of that rate. The physician teaching facility rate for delivery only is $1,007.20 and caesarean delivery only is $1,141.44.

D. Services Billed as Third Party Liability (TPL)

The Primary Contractor is responsible for collecting all third party payments prior to submitting a claim to Medicaid for payment. Recipients with third party coverage are required to follow all program guidelines. Global claims must reflect the payments made by the third party carrier to all subcontractors. Primary Contractor cannot ask maternity recipients to pay any part of another payer's co-pay/deductible. TPL requirements are:

1. TPL Maternity Coverage

    a. Primary Contractor is responsible for collecting all TPL information before submitting a request to Medicaid for payment.

    b. Subcontractors shall file with the other insurer and report amount collected to the Primary Contractor. Primary Contractor must collect the other payer amounts that were obtained from each of their subcontractors. The Primary Contractor will sum up the lesser of: a) the amount paid by the other payer, or b) the contracted rate between the Primary Contractor and the subcontractor. The total sum of all subcontractors will be reported as "**TPL Paid Amount**" on the Medicaid claim.

    c. Primary Contractor's claim shall reflect the total payments as outlined in b above or a documented denial from the TPL insurer.

    d. Denials must be submitted only when the entire claim is denied. If there is a TPL payment on any part of the claim, that amount shall be listed on the claim. When Primary Contractor sends a claim to AMA for drop-out, miscarriages, or other reasons that have TPL payment, the

subcontractor must attach form ALTPL-01 10/12 (Attachment Twenty-four). Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing, and no denial information is submitted.

e. Primary Contractor is responsible for notifying Medicaid's TPL Division by telephone or by mail using Attachment Twenty-three if the recipient has TPL insurance, and it is not listed on the Medicaid file. Primary Contractor must review eligibility for current TPL information prior to submitting claims. To ensure payment, subcontractors should check Medicaid and third party eligibility prior to rendering services.

f. Medicaid shall grant a program exemption for TPL carrier only if recipient is enrolled in an HMO or a managed care plan that requires assignment to a particular provider. An HMO is defined as a TPL carrier which requires the individual to utilize a limited network of providers. In many cases these providers do not accept Medicaid.

2. Recipients with TPL Coverage, excluding Maternity

a. Primary Contractor may notify Medicaid's TPL Division if the recipient has TPL but the contract does not provide maternity coverage or maternity coverage is not provided for dependents. (If maternity coverage is not available due to a waiting period, deductible hasn't been met, etc., Medicaid cannot update its records. The provider must obtain a denial and submit it with the claim.)

b. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division using Attachment Twenty-three.

c. The phone number for Medicaid's TPL Division is based on the recipient's last name. **If the last name of the recipient begins with A-H, call (334) 242-5249; I-P call (334) 242-5280; Q-Z call (334) 242-5254**. If the worker is not available, Primary Contractor may leave information on voice mail. Information which must be left includes: name of caller and phone number, recipient's name and Medicaid number, the name of the insurance company, and the message that the contract does not cover maternity or that recipient is a dependent and dependent maternity benefits are not available.

d. Once this information is loaded into Medicaid's TPL file, Primary Contractor may submit claims without having to attach TPL denial.

3. Recipients with TPL coverage that has lapsed.

a. Primary Contractor must notify Medicaid's TPL Division of the actual month, date, and year the policy lapsed.

b. This information may be provided by phone directly to Medicaid's TPL Division or may be mailed to Medicaid's TPL Division using the form in Attachment Twenty-three.

c. The phone numbers are the same as listed in 2.c. above.

4. The Administrative Review Process

The Administrative Review Process is designed as a mechanism for subcontractors to submit claims, through the Primary Contractor, for consideration of payment. The following guidelines apply:

a. Claims that are received by the Agency from subcontractors will be returned to the Primary Contractor for follow up.

b. When claims are sent through the Administrative Review Process, the Primary Contractor should review the claims to ensure that the claim meets requirements.

c. The Maternity Care Program Administrative Review Form (Attachment Twelve) must be completed by the Primary Contractor and utilized in order for these requests to be processed.

d. Any claim past the time filing limit must have a detailed explanation of why time filing limits were not met.

e. The claim must be submitted to Medicaid <u>within 5 calendar days of receipt of claims</u> from the sub-contractor.

f. When the Primary Contractor sends a claim to AMA for drop-out, miscarriages, high risk transfers, or other reasons that have TPL payment, the subcontractor must attach form ALTPL-01 10/12 (Attachment Twenty-four). Providers are to submit TPL forms when third party payment is made. These forms are scanned and matched electronically with the related claims before processing.

E. Encounter Claims Data

1. Purpose

Primary Contractors must have a system in place to collect, analyze and bill Encounter Claims Data. Encounter Claims Data are the records of services delivered to Medicaid beneficiaries/recipients enrolled in the Maternity Care Program for which a capitated payment is made. These records allow the Medicaid agency to track the services received by Maternity recipients. Encounter data typically comes from billed claims that Primary Contractors and providers submit to the Alabama Medicaid Agency for their services. Encounter Claims Data are essential for measuring and monitoring the Maternity service quality, service utilization, and compliance with contract requirements. The data are also a critical source of information used to set capitation rates.

2. Elements

Data elements which may be captured in Encounter Claims Data will be provided in an electronic format. Examples of data elements are outlined in Attachment Twenty-five. Primary Contractors are required to submit encounter claims on all claims/services reimbursed from the global capitation fee. Claims/services **may include, but are not limited to**:

a. Antepartum Care
b. Outpatient Care/Ultrasounds
c. Deliveries
d. Postpartum Care
e. Assistant Surgeon
f. Associated Services
g. Anesthesia Services
h. Home Visits
i. Ultrasounds
j. Care Coordination
k. Referrals to specialty doctors
l. Labs

3. Standards

A. Encounter Claims Data must be complete and reflective of care provided to recipients.

B. Encounter Claims Data must be submitted according to guidelines outlined in the Vendors Companion Guide located on Medicaid's website.

C. A global payment will not be generated until all Encounter Claims Data have been submitted.

D. All Encounter Claims Data must be submitted to Medicaid within 90 days of the date of delivery.

E. Damages for cost associated with breach of contract may be imposed for Encounter Claims Data not submitted according to guidelines.

F. Billing for Other Districts

a. When a recipient moves to another county outside of the district in which she is eligible and does not change her county code, the billing district will bill the global using their own global rate. The billing district will keep $100 for its time (administrative fee) and send the remaining global and all claims due to the district in which the patient resides. **The Primary Contractor may not bill a drop out and use this policy.**

b. It is the responsibility of every provider to check the recipients' eligibility and county code each time services are provided.

c. The billing district must enter the Encounter Claims Data for the global being billed.

G. High Risk Care

Referrals for high-risk care are the responsibility of the Maternity Care Primary Contractor. High risk care is not carved out of the Maternity District Plan. This includes procedure codes 99241-99245. Each recipient entering the care system must be assessed for high-risk pregnancy status and referred to a Delivering Healthcare Professional qualified to provide high-risk care if the assessment reflects a condition that cannot be appropriately handled in routine prenatal care sites.

1. High Risk Transfers/Reimbursement Methodology

Routine maternity care services provided to a recipient by a Delivering Healthcare Professional and/or Primary Contractor before and after the transfer of a recipient to a teaching physician as defined in Section 4,19-B of the State Plan or to a Medicaid enrolled Board Certified Perinatalogist will be reimbursed **fee-for-service**

a. Services provided by Primary Contractors before and after a high risk transfer: The Primary Contractor may receive an administrative collaborative fee for enrolled recipients who are transferred to high risk care as described above. The Primary Contractor may also receive an administrative collaborative fee for enrolled recipients who receive routine" maternity services from a teaching physician.

The administrative collaborative fee is paid for services provided by the Primary Contractor which include, but are not limited to: administration services, processing administrative review claims for subcontractors, "RMEDE data collection, data entry, and data reporting from the time of enrollment by the Primary Contractor through services provided to the end of the postpartum period for "high risk" recipients and recipients under "routine" care by a teaching physician as defined in Section 4.19-B of the State Plan, and care coordination encounters.

The **administrative collaborative fee** can be billed to the Alabama Medicaid Agency electronically and is not subject to the Administrative Review Process.

Primary Contractors and/or Delivering Healthcare Professionals/Subcontractors cannot bill a delivery code or a full global code for high risk transfers or routine care provided by a teaching physician.

NOTE THE EXCEPTION TO THIS REQUIRMENT:

When maternity care services are subcontracted under the umbrella of a Federally Qualified Health Centers (FQHC) and a teaching physician (as defined in Section 4.19-B of the State Plan), the Primary Contractor may bill an applicable global CPT code. The reimbursement of the FQHC for provision of maternity care services will be the responsibility of the Primary Contractor. The teaching physician will be reimbursed for provision of maternity care services under the fee-for-service payment methodology. In this instance, the administrative collaborative fee cannot be billed by the Primary Contractor."

The procedure code for the administrative collaborative fee is 99199 with a UA modifier indicating high risk transfer or routine maternity care by a teaching physician.

The administrative collaborative" fee is $365.00.

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b. **Services Provided by a Delivering Healthcare Professional/Subcontractor for a High Risk Transfer**

Claims for the provision of services by a Delivering Healthcare Professional/Subcontractor for a high risk transfer will be submitted to the Alabama Medicaid Agency by the Primary Contractor. These claims will be considered for payment through the Administrative Review Process. Reference the Maternity Care Program Operational Manual, Section VIII, D.4., Payment of Services for additional information about the Administrative Review Process.

Types of Claims that may be submitted for consideration of payment include, but are not limited to:

1. Antepartum Care Claims
2. Postpartum Care Claims
3. Associated Services Claims
4. Ultrasounds Claims
5. Claims for Referrals to specialty doctors
6. Lab Claims

Reference the Maternity Care Program Operational Manual, Section V, Services, and the Provider Manual for further details regarding reimbursement methodology.

IX. QUALITY ASSURANCE AND PERFORMANCE IMPROVEMENT

Quality Assurance and Performance Improvement (QAPI) is an integral part of the Maternity Care Program addressing both clinical and nonclinical areas. This section outlines the requirements of the program and the responsibilities of the Primary Contractor and Medicaid. The oversight of QAPI is the responsibility of the Maternity Care Program Associate Director. Each facet of the Quality Assurance and Performance Improvement process has its own unique roles and responsibilities.

A. Primary Contractor Requirements

1. Overall Plan

   a. Is written, clear, and concise and addresses all program requirements including outcomes and processes;

   b. Has defined processes for the collection, analyzing of and reporting of

data;

c. Identifies areas of concern and allows for implementation of corrective action;

d. Corrects significant systemic problems that may be identified through internal surveillance (monitoring and evaluation), complaints, or other mechanisms;

e. Uses clinical care and practice standards that:

1. Are based on reasonable scientific evidence and are reviewed by plan providers;

2. Focus on the process and outcomes of health care delivery, as well as access to care;

3. Are included in provider manuals developed for use by providers/subcontractors or otherwise disseminated to providers as they are adopted;

4. Addresses preventive health education services;

5. Are developed for the full spectrum of populations enrolled in the plan, and for which a mechanism is in place for continuously updating the standards/guidelines.

f. Has sufficient material resources and staff with the necessary education, experience, and training, to effectively carry out its specified activities.

2. Quality Assurance Committee

Each Primary Contractor shall have a Quality Assurance Committee that delineates an identifiable structure responsible for performing Quality Assurance functions. This committee or structure has:

a. Regular meetings – The committee meets on a regular basis at a specified frequency (at a minimum quarterly) to oversee Quality Assurance and Performance Improvement activities. This frequency must be sufficient to demonstrate that the structure/committee is following up on all findings and required actions, with sufficient documentation that is reported to Medicaid quarterly.

b. Established parameters for operating – The role, structure, and function of the structure/committee are specified.

c. Documentation – There are records documenting the structure and the committee's activities, findings, recommendations, and actions. Attachment Sixteen is to be used in documenting quarterly Quality Assurance Committee meeting minutes for reporting to Medicaid.

d. Accountability – The committee is accountable to the Primary Contractor and reports to it (or its designee) on a quarterly scheduled basis on activities, findings, recommendations and actions.

e. Membership – There is active participation in the committee from subcontractors who are representative of the health plan's providers. At a minimum, it is composed of the Program Director or designee, an OB/GYN physician or a delivering physician who practices as a Family Physician or a delivering physician who practices as a General Practitioner, a registered nurse with obstetrical experience, and a licensed social worker. A Medicaid consumer should be included in the meetings. Documentation must support the Primary Contractor efforts for inclusion.

3. Minimum Elements

Each Primary Contractor has the ability to structure its individual Quality Assurance Performance Improvement process to meet the needs of its service and program requirements. The following are the minimum elements that must be present:

a. Mechanism to evaluate the enrollment and referral process.

b. Have a system in place for enrollees that include a grievance process, an appeal process, and access to the State's fair hearing system.

c. Provides for quarterly and annual reporting of Quality Assurance Performance Improvement activities.

d. Allows for the collection and inputting of service specific information into the Service Database. Refer to C. Service Database, of this section for information on the Service Database.

e. Utilizes information obtained from Medicaid's record reviews to incorporate relevant information into their Quality Assurance Performance Improvement process and reports best practices to Medicaid.

f. Conducts ongoing performance improvement projects that focus on clinical and non clinical areas. Refer to F of this section.

g. Conducts Delivering Healthcare Professional medical record reviews on deliveries collecting and reporting, via report card format, the Delivering Healthcare Professional measures indicated in D of this section.

h. Detects both under and over utilization of services by subcontractors and recipients.

i. Addresses the findings of the Delivering Healthcare Professional report cards in the overall Quality Assurance Performance Improvement process.

B. State Requirements

To ensure that the Primary Contractor is meeting program requirements and that the program is achieving its intended outcome, Medicaid must also have a formal Quality Assurance Performance Improvement strategy.

1. Overall Plan

    a. Have a written strategy formulated with the input of stakeholders and formally approved.

    b. Identifies areas of concern and allows for implementation of corrective action.

    c. Corrects significant systemic problems that may be identified through internal surveillance, (monitoring and evaluation), complaints, or other mechanisms.

    d. Provides for feedback to the Primary Contractor and other stakeholders.

2. Minimum State QAPI Elements

    The State will conduct the following minimal activities with the assistance of the Primary Contractor.

    a. Perform medical record reviews to collect data.

    b. Create and maintain a Service Database (Refer to C of this section) to collect service characteristics and outcome information.

    c. Create Primary Contractor Profiles reflecting the elements in E of this section.

d. Review and provide a disposition of Grievances reported to the Agency.

e. Provide oversight of Primary Contractor Quality Assurance and Performance Improvement Projects.

f. Conduct recipient surveys.

g. Review utilization and outcome data.

h. Perform on-site reviews to ensure compliance with program standards. Refer to Section XI of this manual for details on the administrative review process and elements.

i. Provide an annual report of Maternity Care Program activities.

3. State Quality Assurance Performance Improvement Activities

   As described herein and further in Sections X and XI of this Manual, the State will conduct Quality Assurance and oversight activities through a combination of data analyses, Primary Contractor reporting, and onsite reviews. All of these activities will be interwoven to present a complete and accurate reflection of the work that is being accomplished. From these various activities the State will produce an annual report showcasing the impact of the Maternity Care Program to improve birth outcomes.

C. Service Database

1. Description and Purpose

   The Agency will create and maintain a web based database. Primary Contractor will be required to enter certain data elements into the database on each delivery occurring in their program for which they bill a global fee. The purpose of the database will be to collect information on 100% of deliveries so that an accurate reflection of program impact can be obtained. The data will also be the basis of the information for compilation of the Primary Contractor Performance Measures on the Profile. Data input will be directly into the database via a form view or via spreadsheet upload. Attachment Fifteen contains the form delineating the database elements.

2. The database is designed so that Primary Contractor can enter data upon patient enrollment continuing through the postpartum period. All data entry on a patient must be completed within 90 days of the delivery date. Damages for cost associated with breach of contract will be imposed for data not entered within the required timeframe.

The database will be password protected and Primary Contractor will only be able to view information on their patients. Upon contract award additional passwords and training will be provided.

3. Reports

In addition to the Primary Contractor Profiles described below, the Agency will utilize the information from the database to analyze program demographics, care trends, potential quality issues as well as outcome factors.

4 Service Database (RMEDE) Exemptions

A recipient who is awarded exemption status is not required to be entered into the Service database by the Primary Contractor's network. This is generally as a result of deliveries at or less than 21 weeks gestation or other reasons as approved by the Alabama Medicaid Agency. Primary Contractors are required to email any exemption request to the Medicaid Maternity Nurse Review Coordinator assigned to their District. The information will be reviewed for approval or denial based on the criteria specifications. Contractors will be notified in writing if additional information is requested or if exemption request is denied. The request will be documented on a spreadsheet, maintained and filed by the Districts for auditing purposes.

D. Delivering Healthcare Professional Report Cards

DHCP Report cards are just one tool that will be used by the State to gauge program effectiveness in addition to the information provided through the performance improvement projects and recipient surveys. Performance measures will be reviewed for possible adjustment each contract year. Any changes will be communicated to Primary Contractor 60 days prior to effective date.

1. Delivering Healthcare Professional Report Card Measures

Every six months each Primary Contractor will be required to create a report card on each individual Delivering Healthcare Professional and Delivering Healthcare Professional group reporting the following measures:

a. Percentage of medical records containing documentation of DHCP visits which contain the following elements: gestational age, blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery.

b. Percentage of women who have had a determination of blood group (ABO) and negative D (Rh) by the second prenatal care visit.

c. Percentage of Rh negative women with no antibodies who receive Rhogam between 26-32 weeks gestation.

d. Percentage of women who have had glucose tolerance testing performed.

e. Percentage of women who have at least one urine test to screen for asymptomatic bacteriuria.

f. Percentage of Low Birth Weight (LBW < 2500 grams) babies born to Medicaid Mothers.

g. Percentage of Very Low Birth Weight (VLBW < 1500 grams) babies born to Medicaid Mothers.

h. Percentage of women who delivered at less than 37 weeks.

i. Percentage of women (who do not opt out of the test) screened for HIV infection during the first or second prenatal care visit.

2. Definition of Data Elements

Primary Contractor must use the following definitions when applying the measures. This will ensure that all Delivering Healthcare Professionals are being measured consistently and that all Primary Contractors are reporting the measures consistently.

a. Prenatal Visit Elements-DHCP records must contain at a minimum the following: gestational age, blood pressure, weight, urine protein, uterine size, fetal heart tones, and estimated date of delivery at each visit. In the absence of uterine size, or fundal height measurements, documentation should contain evidence of serial ultrasounds to verify fetal growth and development.

b. Blood Group Determination – Notation of results in the prenatal record.

c. Rhogam Injection – notation in the prenatal chart that Rhogam (or equivalent) was given to medically eligible women between 26-32 weeks gestation. NOTE: This measure can only be applied to those women who entered care by 32 weeks gestation and have not been sensitized by a prior pregnancy.

d. Glucose Tolerance Testing or other Diabetic Screening – notation of results in the prenatal record of one of the following tests: glucose tolerance test; 1 hour glucose screen; two hour random blood sugar after a meal or a fasting blood sugar. Testing is not necessary for patients with pre-existing diabetes.

e. Asymptomatic Bacteriuria Screening – notation of the results in the prenatal record.

f. Low Birth Weight – self-explanatory.

g. Very Low Birth Weight – self-explanatory.

h. Delivered less than 37 weeks – self-explanatory.

i. HIV Screening – notation of results in the prenatal record. Must be measured against the number of women who declined testing.

3. Quality Measures and benchmarks are indicated in **Figure 2**.

Figure 2. Delivering Healthcare Professional Quality Measures and Benchmarks.

Measures	Benchmarks
Prenatal Visit Elements	98%
Blood Group Determination	95%
Rhogam Injection	99%
Glucose Tolerance Testing	90%
Asymptomatic Bacteriuria Screening	95%
Low Birth Weight	11%
Very Low Birth Weight	2%
Delivered Less than 37 Weeks	13%
HIV Screening	95%

4. Delivering Healthcare Professionals Sampling Methodology

The Primary Contractor must perform a random sampling of each DHCP every 6 months for measurement of the required elements and the development of professional report cards. The sample size should be 10% but no less than 10 records for each Delivering Healthcare Professional for the period being reviewed.

5. Delivering Healthcare Professionals Review and Reporting Periods

To accommodate program implementation and in order for the review to be reflective of program efforts, a three month phase-in period will be allowed

before Primary Contractors are required to collect and report Delivering Healthcare Professionals measures. Within the District, Primary Contractor should develop a review schedule among their Delivering Healthcare Professionals to ensure that the prescribed numbers of records are reviewed. Delivering Healthcare Professionals Review and Reporting Periods schedule are outlined in **Figure 3**.

Figure 3. Delivering Healthcare Professionals Review and Reporting Period schedule

Delivery Date of Service	Review Period	Report Card Due
June-November	February-April	May
December-May	August-October	November

6. Delivering Healthcare Professional Report Card Format
   Primary Contractor must use the format in Attachment One to report Delivering Healthcare Professionals measures. For those Delivering Healthcare Professionals in group practices, defined as three or more physicians, the measures are to be reported per Delivering Healthcare Professionals and per Group.

   Primary Contractor is required to develop a system to mask their individual Delivering Healthcare Professionals so that results from all the district's DHCPs can be provided. The algorithm used to mask providers should contain logic that links providers within a group to allow for further analyses of the data that may be necessary.

E. Primary Contractor Profile Measures

1. Source of Data
   Medicaid will use the Service Database, Grievance Log and results from the recipient surveys to create the Primary Contractor Profile.

   a. Web Elements

      Medicaid, based on information obtained through the Service Database, will produce biannual Primary Contractor Profiles reflecting data on 100% of all deliveries. In addition to program demographics, the following elements will be measured and reported.

      1. Percentage of women with first doctor’s visit less than 14 weeks gestation

      2. Percentage of low birth weight (LBW < 2500 grams) babies born to Medicaid mothers

3. Percentage of very low birth weight (VLBW < 1500 grams) babies born to Medicaid mothers

4. Percentage of women who complete a family planning visit prior to the 60th postpartum day

5. Number of prenatal visits that contain all of the prenatal elements/number of paid deliveries

6. Percentage of very low birth weight babies born at appropriate facilities for high-risk deliveries and newborns

7. Percentage of babies born prior to 37 weeks gestation

8. Number of women who quit smoking while pregnant/number of smokers

9. Percentage of diabetic women who have at least one session with a registered dietician or certified diabetic educator at less than 32 weeks gestation.

10. Percentage of women identified as breast feeding at postpartum visit

11. Percentage of women who received a Care Coordination visit after delivery prior to discharge from the hospital

12. Percentage of women who complete a postpartum visit prior to the 60th postpartum day

b. Grievances and Appeals

Grievances and appeals as reported by category on the quarterly grievance log. Refer to H of this section for details on the grievance system.

c. Recipient Surveys

Refer to I of this section for details on the Recipient Explanation of Medicaid Benefits process.

2. Definition of Primary Contractor Data Elements

a. Percentage of women with first doctor's visit less than 14 weeks gestation

b. Percent of Low Birth Weight – self-explanatory

c. Percent of Very Low Birth Weight – self-explanatory

d. Percent of family planning visits completed prior to the 60th postpartum day. Number of prenatal visits that contain all the prenatal elements

e. Percent of Very Low Birth Weight at high-risk facilities – Facilities as defined by the Alabama Department of Health as being as Level A or B hospital. **Level A**: **USA, UAB**; **Level B**: **Huntsville Hospital**, **DCH-Tuscaloosa, DCH-Northport**, **Brook Wood**, , **Princeton, St. Vincent's East**, **St. Vincent's**, **Trinity Medical Center**, **Montgomery Baptist South**, and Medical Center Inc., for Columbus Georgia.

f. Percentage of babies born prior to 37 weeks gestation – defined as 36 and 6/7ths weeks or earlier

g. Number of women-who quit smoking while pregnant – self-explanatory

h. Percentage of diabetic women who have at least one session with a registered dietician or certified diabetic educator – self-explanatory

i. Percentage of women identified as breast feeding at postpartum visit– self-explanatory

j. Care coordination

k. Percent of postpartum visits completed prior to the 60th postpartum day

3. The Alabama Medicaid Agency will generate performance reports to evaluate the performance of Primary Contractors, subcontractors and the effectiveness of the Maternity Care Program. The reports will capture delivery dates as indicated below and will be issued according to the established timeline in **Figure 4**.

   In order to ensure timely reporting by the Alabama Medicaid Agency, the Primary Contractor is encouraged to enter information into the Alabama Medicaid Agency's Maternity Care Program database on an ongoing basis.

Figure 4. Performance Reports Schedule

Delivery Date of Service	Profile Issued
January-March	July
April-June	October
July-September	January
October-December	April

F. Performance Improvement Projects (PIPS)

The purpose of conducting a Performance Improvement Project is to improve relevant areas of clinical and non-clinical care that significantly impact enrollee health, function, and satisfaction in the Maternity Care Program. One Performance Improvement Project will be required by Medicaid per year unless otherwise directed.

G. Quality Improvement Activity Summary (QIAS)

In addition to specific Performance Improvement Projects described above, each Primary Contractor must have an ongoing quality assessment and performance improvement program for the services it furnishes to its enrollees. The Quality Improvement Activity Summary allows the Primary Contractor to have in effect a process for its own evaluation of the impact and effectiveness of its quality assessment and performance improvement program. Attachment Ten contains the reporting format. Attachment Ten-A is an example of a completed project.

The Quality Improvement Activity Summary records quality assessment and performance, providing an overview of activity, why activity is relevant, and opportunities for improvement and interventions for the District. This form is maintained by the Primary Contractor and sent to Medicaid on a quarterly basis.

Quality improvement activities must focus on clinical and nonclinical areas and involve the following:

1. Measurement of performance using objective quality indicators.
2. Implementation of system interventions to achieve improvement in quality.
3. Evaluation of the effectiveness of the interventions in improving birth outcomes.
4. Planning and initiation of activities for increasing or sustaining improvement.

H. Grievance and Appeal System

Each Primary Contractor must implement and maintain a grievance and appeal system that includes a grievance process, an appeal process and access to Medicaid's fair hearing process. The Primary Contractor is required to send a notice of any adverse action to the enrollee and such notice must meet the notice requirements set forth in 42 CFR 431, Subpart E. The regulations as

specified at 42 CFR 438.228 and 438.400 et al. must also be followed. The following is a general summation of the requirements.

1. General

   a. A grievance is defined as an expression of dissatisfaction about any matter other than an action.

   b. An action is the denial or limitation of a requested service, the reduction, suspension or termination of a previously authorized service, the denial of payment for a service or the refusal of the Primary Contractor or subcontractor to act in a timeframe specified.

   c. An appeal is defined as the request for review of an action.

   d. Medicaid and the Primary Contractor must have a process in place to receive and resolve grievances.

   e. The Primary Contractor must provide grievance and appeal procedures to all recipients and subcontractors, including recipients' right to a fair hearing.

   f. The Primary Contractor must have written policies that document and outline the grievance and appeal process.

   g. Primary Contractor must accept grievances either orally or in writing.

   h. Primary Contractor must notify subcontractors and recipients in writing of the disposition of the grievance at each level.

   i. The Primary Contractor must maintain records of grievances and appeals. On a quarterly basis, the Primary Contractor must submit to Medicaid the Grievance Log as defined in Attachment Eighteen. Instructions for completing the Grievance Log are defined in Attachment Eighteen-A.

   j. Medicaid will report any grievances received directly to the Primary Contractor. It is the responsibility of the Primary Contractor to handle the grievance as if it was received directly. Primary Contractors are required to report follow up, findings and outcome of the grievance back to the Medicaid within ten business days of receipt.

2. Primary Contractor Grievance System

   The Primary Contractor must:

a. Give recipients participating in the program reasonable assistance in completing forms and other procedural steps including, but not limited to, providing interpreter services and toll-free numbers with TY/TDD and interpreter capability.

b. Acknowledge receipt of each grievance and appeal.

c. Ensure that grievances and appeals are handled in an objective and fair manner.

d. Make specific policies and procedures available addressing the grievance system including recipient rights, timeframes, assistance availability and the toll-free number to file oral grievances and appeals.

3. Grievance Process

Each Primary Contractor should have a designated individual who can receive the grievance and act to resolve the grievance on behalf of the recipient. These type grievances should be resolved within ten business days of receipt. If the grievance is of an urgent or immediate action, then it should be acted on within 48 hours. If an enrollee seeks disenrollment, the grievance process must be completed in time to permit the disenrollment (if approved) to be effective in accordance with the timeframe specified in 42 CFR 438.56(e).

If a grievance cannot be resolved at this level, then the grievance should be referred to the Primary Contractor's Grievance Committee. At this point the grievance becomes an appeal.

4. Appeal Process

Each Primary Contractor should have specific procedures for handling appeals based on the requirements found at 42 CFR 438.400 et al. Below is a general summation of the requirements.

a. A recipient or a provider acting on behalf of the recipient can file an appeal to the Primary Contractor,

b. The appeal must be filed within 45 calendar days from the date of the action.

c. An appeal can be filed orally but must be followed with a timely written, signed appeal.

d. The Primary Contractor must have written policies governing appeals.

e. Appeals must be resolved within 45 calendar days of receipt. Extensions may be granted if requested by the enrollee.

f. The Primary Contractor must have a documented process for expedited appeals.

5. State Fair Hearing Process

   If a recipient is not satisfied with the resolution of her appeal by the Primary Contractor, she may request a fair hearing from Medicaid. Fair Hearings are governed by Chapter Three of the Alabama Medicaid Administrative Code. The Primary Contractor must make available to recipients the right to a fair hearing, the method for obtaining a fair hearing and the rules that govern representation. The same information must be available to subcontractors and recipients.

I. Recipient Explanation of Medicaid Benefits (REOMBs)

The Agency, through its fiscal agent liaison, sends a recipient survey to those women delivering through the Maternity Care Program. The purpose of the survey is to solicit the patient's input on the care received through the program. It is also intended to gauge whether program requirements are being met and the patient's overall perception of program impact.

The surveys are distributed on a monthly basis to two percent of women delivering three months prior to the requesting month. The REOMBs schedule is established on a quarterly basis

Medicaid will provide each Primary Contractor with the results from the women's surveys within their districts. Primary Contractor is required to share these findings with their subcontractors.

In addition, findings from the REOMBs will be reported on the Primary Contractor Profile comparing each district results.

J. Delegation of Quality Assurance Performance Improvement Activities

The Primary Contractor remains accountable for all Quality Assurance Performance Improvement functions, even if certain functions are delegated to other entities. If the Primary Contractor delegates any Quality Assurance Performance Improvement activities to contractors:

1. There must be written description of: the delegated activities; the delegate's accountability for these activities; and the frequency of reporting to the primary contractor.

2. The Primary Contractor must have written procedures for monitoring and evaluating the implementation of the delegated functions and for verifying the actual quality of care being provided.

3. There must be evidence of continuous and ongoing evaluation of delegated activities, including approval of quality improvement plans and review of regular specified reports.

K. Coordination of Quality Assurance Activity with Other Management Activity

The findings, conclusions, recommendations, actions taken, and results of the actions taken as a result of Quality Assurance Performance Improvement activity are documented and reported to appropriate individuals within the organization and through established channels.

1. Quality Assurance Project information is used in re-credentialing, re-contracting, and for annual performance evaluations.

2. Activities are coordinated with other performance monitoring activities, including utilization management, risk management and resolution, and monitoring of member complaints and grievances.

3. There is a linkage between Quality Assurance and the other management functions of the health plan, such as:

   a. network changes
   b. benefits redesign
   c. medical management systems (e.g. pre-certification)
   d. practice feedback to physicians
   e. recipient education

L. Performance Measures

The following is a list of the specific measures and process of review:

a. Medical record documentation must support that the district has 25% of the total number of smoking mothers who enroll for care during the first year of the contract period to quit smoking while pregnant and continue to cease from smoking until the postpartum visit. This information will

be monitored through the Agency web data base (Real-time Medical Electronic Data Exchange) and through medical record reviews performed by Agency staff.

b. The establishment and/or maintenance of at least one Centering Pregnancy site for the entire year per district. Agency Staff may provide an on-site visit to the site.

c. Medical record documentation must support that 50% of all diabetic women enrolled for care in the district have at least one session with a registered dietician or certified diabetic educator at less than 32 weeks gestation. This information will be monitored through Real-time Medical Electronic Data Exchange and through medical record reviews performed by Agency staff. .

d. Medical record documentation must support that 80% of all delivering women served by the district complete a family planning visit by the 60th postpartum day. This information will be monitored through Agency web data base and through medical record reviews performed by Agency staff.

e. Medical record documentation must support that all delivering women served by the districts received 61-80% of the expected prenatal visits. This information will be monitored through Real-time Electronic Medical Data Exchange and through medical record reviews performed by Agency staff.

f. Medical record documentation must support that 80% of documented prenatal visits per total number of paid deliveries contained all of the required prenatal visit elements. This information will be monitored through Real-time Electronic Medical Data Exchange and through medical record reviews performed by Agency staff.

g. Medical record documentation must support that a minimum of 25% of the total number of deliveries served are identified as breast feeding mothers at their postpartum visit. This information will be monitored through Real-time Medical Electronic Data Exchange and through medical record reviews performed by Agency staff.

h. Medical record documentation must support that 75% of the number of deliveries in the district annually complete the first doctor's visit at <14 weeks gestation. This information will be monitored through REMEDE and through medical record reviews performed by Agency staff.

i. Medical record documentation must support that a minimum or 80% of all delivering women complete a postpartum visit prior to the 60th postpartum day.

X. RECORDS AND REPORTS

A. Record Requirements

1. Records

   The Primary Contractor must maintain books, records, documents, and other evidence pertaining to the costs and expenses of this contract (hereinafter collectively called the "records") to the extent and in such detail as must properly reflect all net costs for which payment is made under the provisions of any contract of which this contract is a part by reference or inclusion.

   In accordance with 45 CFR §74.164, and 42 CFR 438.6(g), the Primary Contractor shall maintain financial records, supporting documents, statistical records, and all other records pertinent to the Alabama Medicaid Program for a period of three years from the date of the final payment made by Medicaid to Contractor under the contract. However, if audit, litigation, or other legal action by or on behalf of Medicaid or the Federal Government has begun but is not completed at the end of the three year period, or if audit findings, litigation, or other legal action have not been resolved at the end of the three year period, the records shall be retained until resolution. Subsequent to the contract term, documents shall be returned to Medicaid within three working days following expiration or termination of the contract. Micro-media copies of source documents for storage may be used in lieu of paper source documents subject to Medicaid approval.

   Primary Contractor/Subcontractors agrees that representatives of the Comptroller General, Health Human Services, the General Accounting Office, the Alabama Department of Examiners of Public Accounts, and Medicaid and their authorized representatives shall have the right during business hours to inspect and copy Primary Contractor's/Subcontractors books and records pertaining to contract performance and costs thereof. Primary Contractor/Subcontractor shall cooperate fully with requests from any of the agencies listed above and shall furnish **free of charge** copies of all requested records. Primary Contractor/Subcontractor may require that a receipt be given for any original record removed from Primary Contractor's premises.

   A file and report retention schedule must be developed by the Primary Contractor and approved by Medicaid. Primary Contractor must maintain

and Medicaid shall approve the retention schedule and all changes.

2. Substitution of Records

The Primary Contractor may, in fulfillment of its obligation to retain its records as required by this article, substitute clear and legible photographs, microphotographs or other authentic reproductions of such records after the expiration of three (3) years following the last day of the fiscal year in which payment to the Primary Contractor was made, unless a shorter period is authorized by Medicaid. The State Records Commission approves records retention schedules.

3. Medical Records

Primary Contractor and subcontractors shall ensure that a medical record system is maintained within the State of Alabama in accordance with §2091.3 and §2087.8 of the State Medicaid Manual which makes available to appropriate health professionals all pertinent information relating to the medical management of each recipient. All entries on medical records must be written in ink or typewritten and authenticated by the signature or initials of the health care professional.

B. Reporting Requirements

1. Report Submission

a. Reports are to be submitted as specified in the description of reports (#2 below).

b. Primary Contractor must be responsible for timeliness, accuracy, and completeness of reports as defined below:

1. Timeliness – Reports and other required Service Database data must be received on or before scheduled due dates.

2. Accuracy – Reports and other required Service Database data must be prepared in conformity with appropriate authoritative sources and/or Medicaid defined standards.

3. Completeness – All required information must be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.

4. Primary Contractor must agree to be responsible for continued reporting beyond the term of the contract. For example, processing claims and reporting encounter data must likely continue beyond the

term of the contract because of lag time in filing source documents by subcontractors.

5. Medicaid requirements regarding reports, report content and frequency of submission of reports are subject to change at any time during the terms of the contract. Primary Contractor must comply with all changes specified by Medicaid.

6. Reporting requirements are based on calendar dates.

7. The "to" contained in the subsequent chart indicates to where the report should be submitted. Maternity Care Program refers to the Associate Director or a designee as directed by the Associate Director. Specific email addresses will be provided prior to contract implementation.

2. Reports

The following are the reports that are required on a routine basis. Details on specific reporting requirements may have been contained in other sections of the Operational Manual and referred to below. Failure to deliver reports in the manner and timeframe specified in **Figure 5** may result in damages for cost associated with breach of contract. Form format and requirements may change as deemed necessary be Medicaid.

Figure 5. Reporting Requirements

Report Name	To	Media	Format	Timeframe	Due
Service Database	n/a	Web-based	In the format as designated in the Web based instructions	Data must be entered within 90 days of the delivery	Within 90 days of delivery
Global Summary Report	MCP	Email	Excel as indicated in the format as specified in Attachment Nineteen	Quarterly	Within 45 days of the end of the quarter being reported
Organizational Structure	MCP	e-mail	Word	Annual and upon change	January 1st and/or within 5 days of occurrence

Provider Network	MCP	e-mail	Excel as indicated in the format as specified in Attachment Twenty	Annual and upon change	January 1st and/or within 5 days of occurrence (exception: due weekly for 30 days after contract award)
Application Assisters	MCP	e-mail	Word as indicated in the format specified in Attachment Six	Annual and upon change	Within 45 days of the end of the year and within 45 days of any change
Quality Improvement Activity Summary	MCP	e-mail	Word as indicated in the format specified in Attachment Ten	Quarterly	Within 45 days of the end of the quarter being reported
Grievance and Appeal Log	MCP	e-mail	Word or excel format as indicated in the format specified in Attachment Eighteen	Quarterly	Within 45 days of the end of the quarter being reported
Quality A Assurance Committee Meeting Minutes	MCP	e-mail	Word as indicated in the format specified in Attachment Sixteen	Quarterly	Within 45 days of the end of the quarter being reported
Managed Care Organization (MCO)Experience Report	MCP	email	As indicated in the format as provided by the Alabama Medicaid Agency	Annually	Within 45 days of the end of each calendar year
Quality Improvement Tracking Log	MCP	e-mail	Word as indicated in the format specified in Attachment Seventeen	Quarterly	Within 45 days of the end of the quarter being reported
Sale, Exchange, Lease of Property	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Loans and/or Extension of Credit	MCP	Paper	Word	Occurrence	Within 5 days of occurrence
Furnishing for Consideration of Goods &	MCP	Paper	Word	Occurrence	Within 5 days of occurrence

Services					

3. Report Details

a. Service Database
The purpose of this report is to collect specifics on each delivery for which the Primary Contractor receives payment. Information will be entered via a web-based database as described in Section IX.C.

b. Global Summary Report:
The purpose of this report is to collect specifics on amounts paid to subcontractors for services reimbursed through the global fee. The format and instructions are included in Attachment Nineteen.

c. Organizational Structure
This report indicates for Medicaid the individuals involved in the Primary Contractors' organization. Significant changes must be reported to the Maternity Care Program Associate Director within 5 days of occurrence in a word format.

d. Provider Network
This report must be reflective of all subcontractors in the Primary Contractors' network. Complete demographic information must be included, the service offered and the providers NPI number. The format and instructions are included in Attachment Twenty.

e. Application Assister services Primary Contractor shall submit a list of counties and names of assigned Application Assisters and the name(s) of the Application Assisters' trainer to the Maternity Care Program Associate Director or designee annually and upon change. The format is included in Attachment Six.

f. Quality Improvement Activity Summary
This report must summarize the Primary Contractors' Quality Improvement activity for the quarter. Details are contained in Section IX.G. The format and instructions are included in Attachments Ten and Ten-A.

g. Grievance Log
This report allows Medicaid to track issues as they arise as well as assure that each issue is resolved. Details are contained in Section IX.H. The format and instructions are included in Attachments Eighteen and Eighteen-A.

h. Quality Assurance Committee Meeting Minutes

This report allows the Quality Assurance Division to focus on quality improvement and quality concerns in individual districts and how improvements initiatives are implemented and the concerns are being resolved. Details are contained in Section IX.A. The format for reporting Quality Assurance Committee Meeting minutes is located in Attachment Sixteen.

i. MCO Experience Report
This report will be used during the development of delivery rates for the Alabama Medicaid Population. Each Contractor will be required to complete the report for each of its districts.

j. Tracking Log
A means by which the Primary Contractor can identify and track problems and/or issues noted within their Districts. Identified problems or issues are taken to the QA Committee for discussion and recommendations.

k. Sale, Exchange, Lease or Property;
These reports are Centers for Medicare and Medicaid Services required for Managed Care Organizations and are required in a word format.

l. Loans or Extension of Credit
These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

m. Furnishing for Consideration of Goods and Services
These reports are centers for Medicare and Medicaid Services requirements for Managed Care Organizations and are required in a word format.

XI. MEDICAID OVERSIGHT

A. General

Medicaid shall monitor Primary Contractor performance through a combination of performance measures, medical record reviews and administrative reviews. The purpose of oversight activities is to ensure that contract requirements are being met, standards of care are being implemented and enforced, and that Primary Contractors are meeting the expectations of the Delivering Healthcare Professional.

B. Administrative Reviews

1. Purpose
   To measure performance, each Primary Contractor will be visited at least annually on-site to ensure compliance with program requirements.

2. Elements of the Administrative Review are detailed in **Figure 6**.

Figure 6. Administrative Reviews Elements

Subcontractors not enrolled as Medicaid providers
Valid Subcontracts (credentialing and licensure)
Delivering Healthcare Professionals have hospital privileges at a facility that provides delivery services
Claim payment within timeframes
Staff knowledge of billing/reimbursement policies
Training (Subcontractor and Care Coordinator) as required
Application Assister Requirements
Delivering Healthcare Professional Choice Requirements

3. Standards
   If after the Administrative review, the Primary Contractor is found to not be meeting the requirements, the following damages for cost associated with breach of contract as indicated in **Figure 7** will be imposed. As indicated, corrective action will be allowed for some program elements with imposition of damages for cost associated with breach of contract as a final act.

Figure 7. Administrative Measures and Damages for Cost Associated with Breach of Contract.

Measure	**Damages for Cost Associated with Breach of Contract**
Subcontractor not Enrolled with Medicaid	1st occurrence: Corrective Action, 2nd occurrence: $500 per provider not enrolled
Valid Subcontracts	1st occurrence: Corrective Action, 2nd occurrence: $500 per subcontract not meeting requirements
DHCP have hospital privileges	1st occurrence: Corrective Action 2nd occurrence: $500 per DHCP not having hospital privileges
Claim payment within timeframes	95% audit sample of claims paid

	within timeframes, $100 per incident for payments not meeting timeframes
Staff knowledge of billing/reimbursement policies	1st occurrence:, Staff re-training 2nd occurrence: $100 per incident thereafter.
Training (Subcontractor and Care Coordinator) as required	$500 training session not completed
Application Assister services	$500 per week in which there is no access to an Application Assister in all counties
Delivering Healthcare Professional Choice Requirements	1st occurrence: Corrective Action 2nd occurrence: $500 per choice requirements not being met

C. Medical Record Reviews

1. Purpose

   The purpose of the Medical Record Reviews is to ensure that each Primary Contractor is providing quality maternity care to their recipients, determine the effectiveness of the Maternity program and to ensure services are provided according to federal and state guidelines. This will be accomplished by conducting periodic reviews to evaluate the effectiveness and adequacy of postpartum home visits, care coordination, and smoking cessation efforts. Medical Record Reviews will be performed in addition to the elements that are measured from the Web Database as described in Section IX.C.

2. Sample Size/Process

   Reviews will be conducted on a semi-annual basis as explained in the Operational Manual, Section XI.C.2.

   The sample number of records will be chosen randomly from a DSS Query generated for a specific period of time prior to the review but in no case reflective of less than three months prior to the review month. A request for recipient records will be sent to the Primary Contractor requesting that patient records be sent back to the Medicaid Managed Care Division for review. The Primary Contractor will be responsible for obtaining all record information for review which includes documentation from the DHCP, Hospital, etc. The subcontractor or the Primary Contractor cannot charge for these records.

3. Findings

After the review is completed and all data compiled, Primary Contractor will be provided a summary of the findings. Statewide statistical reports will be generated after all District reviews are completed, excluding Service Database reviews. Further review and/or a request for a corrective action plan may be necessary dependant on Medical Record and Service Database Review findings.

4. Elements and expectations of the Medical Record Review are detailed in **Figure 8**.

Figure 8. Medical Record Reviews Elements and Expectations

Measure	What it is	Expectation
Care Coordination Encounters	The percentage of recipients for which a care coordination encounter was completed in the hospital prior to discharge. If no encounter was completed in the hospital prior to discharge, were two attempts made to contact the recipient within 20 days of delivery so that the encounter could be accomplished.	90% of recipients receive an encounter.
Documentation of Care Coordination Activities	All encounters are documented	100% of encounters are documented
Content of Care Coordination	Required encounters meet the guidelines specified in Section VI of the Operational Manual.	95% of encounters meet the required guidelines.
Service Database Verification- Content of data elements in the Service Database	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) entered into RMEDE is reflective	90% of the total selected audit sample Service Database elements should mirror medical record and claims

	of medical records and claims documentation.	documentation.

5. Standards

If program requirements are not met, corrective action will be requested. Districts will implement a Plan of Correction and submit a signed report to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Primary Contractor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract as described in **Figure 9**.

Figure 9. Medical Record Reviews Standards and Damages for Cost Associated with Breach of Contract.

Measure	**Damages for Cost Associated with Breach of Contract**
Care Coordination Encounters	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient
No Documentation of Care Coordination Activity	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $700 per recipient
Content of Care Coordination	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark with no improvement noted, $500 per recipient
Content of Service Database- RMEDE Verifications Source: Medical Record Reviews and claims data	1st Occurrence: Letter of Concern 2nd occurrence: Corrective Action Subsequent Occurrences if below established benchmark, $500 per occurrence

D. Missing in Service Database (RMEDE) Reviews

1. Purpose
The purpose of the Missing in Service Database (RMEDE Review) is to

ensure the Primary Contractor has entered valid data into RMEDE in a timely fashion for recipients for whom a global fee was paid.

Sample Size/Process
Reviews will be conducted quarterly, as explained in Operational Manual, Section XI.C.2.

All deliveries for an identified quarter will be chosen randomly from a DSS Query using claims data generated for a specific period of time.

2. Findings

After the review is completed and all data compiled, Primary Contractors will be provided a summary of the findings. Further review and/or a request for a corrective action plan may be necessary dependent on the review findings.

3. Elements and expectations of the Service Database (RMEDE) reviews are detailed in **Figure 10**.

Figure 10. Service Database (RMEDE) Reviews Elements and Expectations

Measure	What it is	Expectation
Timeliness and valid Service Database Entries for Missing in RMEDE Reviews	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.	100 % of patients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date and marked as complete.
Validity of Service Database Entries for Missing in RMEDE Reviews	The percentage of recipients for whom a delivery was paid by the Alabama Medicaid Agency (excluding exemptions) are entered into the Service Database within 90 days of the delivery date with valid data compared to claims data.	95% of data entry for each recipient who delivered in the district review period will be without error.

4. Standards

If program requirements are not met, corrective action will be requested. Districts will implement a Plan of Correction and **submit written and signed report** to the Medicaid Maternity Care Program via fax, email or United States Postal Service within 15 working days of the request from Medicaid. The Primary Contractor must follow-up on identified issues to ensure that actions for improvement have been effective with a written and signed report of findings submitted to the Medicaid Maternity Care Program six months after the Corrective Action Plan has been implemented. If improvement is not noted in subsequent reviews, further actions may be taken including damages for cost associated with breach of contract as described **Figure 11.**

Figure 11. Service Database (RMEDE) Reviews Standards Damages for Cost Associated with Breach of Contract

Measure	Damages for Cost Associated with Breach of Contract
Timeliness of Service Database Data Entries for Missing in RMEDE Reviews Source: Claims Data	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark, $500 per recipient
Validity of Service Database Missing in RMEDE Reviews Source: Claims Data	1st occurrence: Corrective Action 2nd occurrence: if below established benchmark, $100 per recipient

E. Corrective Action

The following standards will apply when the need for corrective action is identified:

1. There must be a written, defined corrective action plan.

2. The corrective action plan must be signed by the director.

3. The plan must be acceptable to and approved by AMA.

4. The Plan must be submitted within the required timeframe.

5. The plan must include:

a. Specification of the types of problems requiring remedial/corrective action.

b. Specification of the person(s) or body responsible for making the final determinations regarding quality problems.

c. Specific actions to be taken.

d. Provision of feedback to appropriate health professional, providers and staff.

e. The schedule and accountability for implementing corrective actions.

f. The approach to modifying the corrective action if improvements do not occur.

g. Procedures for terminating the affiliation with the physician or other health professional or provider.

h. Assessment of effectiveness of corrective actions. As actions are taken to improve care, there must be monitoring and evaluation of corrective actions to assure that appropriate changes have been made. In addition, changes in practice patterns are tracked.

i. Primary Contractor assures follow-up on identified issues to ensure that actions for improvement have been effective.

Imposition of these damages for cost associated with breach of contract may be in addition to other contract remedies and does not waive Medicaid's right to terminate the contract.